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APPEAL

Members in arrears are requested to pay their Subscription at an early date. The Subscription be sent in favour of Indian Hospital Association and sent to the Secretary General, IHA, C-II/72, Shahjahan Road, New Delhi-110 011.

Dr. S. D. Vohra
Treasurer

OVERVIEW

INTERNATIONAL HOSPITAL WORKSHOP ON HOSPITAL AND PRIMARY HEALTH CARE

An INTERNATIONAL WORKSHOP ON HOSPITAL AND PRIMARY HEALTH CARE was held at Hotel Taj Mahal, New Delhi from 21st to 23rd August '88. This Workshop was jointly organised by the INDIAN HOSPITAL ASSOCIATION (IHA), New Delhi and INTERNATIONAL HOSPITAL FEDERATION (IHF), London and supported by W.K. KELLOGG FOUNDATION, U.S.A., UNICEF, REGIONAL OFFICE FOR SOUTH CENTRAL ASIA and with the knowledge of the MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, New Delhi and WORLD HEALTH ORGANISATION, SOUTH EAST ASIA REGIONAL OFFICE (SEARO), New Delhi. One of the purpose of the Workshop was to review the NEW DECLARATION ON HOSPITAL AND PRIMARY HEALTH CARE which was evolved during the INTERNATIONAL CONFERENCE ON HOSPITAL AND PRIMARY HEALTH CARE held from 20th to 25th January '85 at New Delhi.

The Workshop was inaugurated by DR. U. KO KO, Regional Director, World Health Organisation, SEARO, New Delhi. The inaugural session was also addressed by MR. ROLF C. CARRIERE, Chief, Health and Nutrition, UNICEF, Regional Office for South Central Asia, MR. ROBERT A. DE VRIES, Programme Director, W.K. KELLOGG FOUNDATION, U.S.A. and DR. ROY J. GERARD, Director, Kellogg International Fellowship Programme in Health, U.S.A. and MR. MILES C. HARDIE, Member, Steering Committee, KIFPH and former Director General, IHF, London. The Welcome Address during the inaugural session was presented by DR. M.S. NANDA, President, Indian

Hospital Association and Chairman, Reception Committee, New Delhi. Vote of Thanks was presented by DR. P.N. GHEI, Secretary General, Indian Hospital Association and the Organising Secretary General of the International Workshop. He also read messages received.

DR. U. KO KO, Regional Director, WHO, SEARO, New Delhi went round the exhibition organised depicting various interventions in Urban Health Care with particular emphasis to improving Child Survival like Growth Monitoring, Oral Re-hydration, Breast Feeding, Health Education, Immunisation, Child Spacing and Nutrition.

The unique feature of this Workshop was that it was not only "NO SMOKING" but "NO SMOKING - NO TOBACCO" Workshop. The Workshop was attended by 290 delegates from different WHO Regions, KIFPH Fellows, and Members of Kellogg's Steering Committee.

The Workshop had a number of SCIENTIFIC SESSIONS. An innovative feature of the Workshop was DEMONSTRATION OF YOGA by students of the International Foundation of Yoga and Natural Health. The recommendations of the INTERNATIONAL CONFERENCE ON HOSPITAL AND PRIMARY HEALTH CARE OF 1985 were discussed in the WRAP-UP SESSION and after detailed discussions the concensus was arrived on a set of recommendations which were agreed to be called the 'NEW DELHI DECLARATION ON URBAN HEALTH CARE'. The New Delhi Declaration on Hospital and Primary Health Care of 1985 and the New Delhi Declaration on Urban Health Care of 1988 are included in the Proceedings.

The SILVER JUBILEE ISSUE of official IHA Journal 'HOSPITAL ADMINISTRATION' was released by DR. HERBERT L. WHITTIER, Associate Director, Kellogg International Fellowship Programme in Health, U.S.A. DR. B.L. KAPUR ORATION of IHA which was this year held during the Workshop was delivered by MR. ROBERT A. DE VRIES, Programme Director, W.K. Kellogg Foundation, U.S.A. The KEY NOTE ADDRESS were presented by DR. SOMBHONG KUTRANON, Regional Advisor, Community Health Services, WHO, SEARO, DR. CHEN ZHIXING, Vice Director, Shanghai Ninth People's Hospital, Shanghai, People's Republic of China and MRS. PRAMILA GHEI, KIFPH Fellow, Secretary and Business Editor, IHA, New Delhi.

The participants from abroad also visited FIELD PRACTICE AREA in Urban Delhi to witness the PHC interventions in action.

Number of other National and International Organisations also provided support. The Workshop had professionals like Health Managers, Primary Health Care Experts, Medical Doctors, Community Representatives, Community Health Nurses Acadamecians, Para-Medicals and experts in Operation Research. It is because of this multidisciplinary participation that the New Delhi Declaration on Urban Care was arrived upon.

We would like to thank all the National and International Organisations who supported this Workshop especially the W. K. Kellogg Foundation and the Ministry of Health and Family Welfare, Government of India without whose co-operation this Workshop would not have been a successful one.

P.Ghei

राष्ट्रपति का प्रेस सचिव
Press Secretary to the President

No. F. 2-M/88

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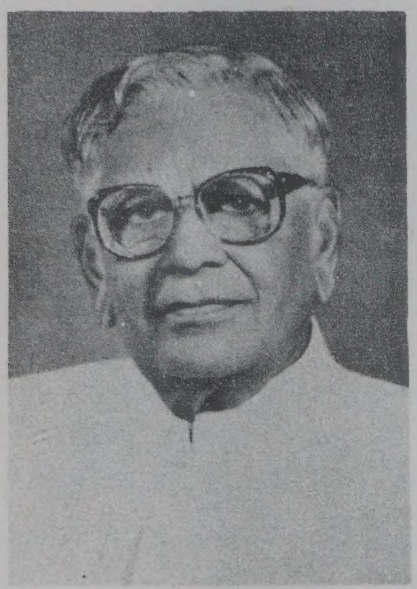
President's Secretariat
Rashtrapati Bhavan
New Delhi-110004

August 11, 1988



Dear Dr. Ghei,

The President of India is glad to learn that the Indian Hospital Association is organising an International Workshop on Hospital and Primary Health Care in New Delhi from August 21-23, 1988. The President sends his greetings to the organisers and the participants and best wishes for the success of the Workshop.

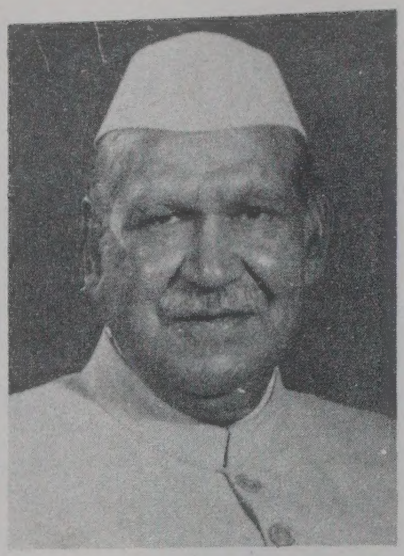
Yours sincerely,

K. Suryanarayana

(K. Suryanarayana)

Dr. P.N. Ghei,
Secretary General,
Indian Hospital Association,
C-II/72, Shahjahan Road,
New Delhi - 110 011

सत्यमेव जयते



उप-राष्ट्रपति, भारत
नई दिल्ली
VICE-PRESIDENT
INDIA
NEW DELHI

August 2, 1988

MESSAGE

It gives me great pleasure to know that Indian Hospital Association, New Delhi in collaboration with International Hospital Federation, London is organising an 'International Workshop on Hospital and Primary Health Care' in New Delhi from 21st to 23rd August, 1988.

This Workshop, I understand, is a follow up of an earlier International Conference on similar subject held in New Delhi in 1985 at which the conclusions of the earlier Conference would be discussed and reviewed. I hope that the ensuing Workshop will make practical recommendations to improve the interface of 'Hospital and Primary Health Care' to the community.

I send my best wishes for the success of the deliberations of the Workshop.

S.D. Sharma

(S.D. Sharma)

सत्यमेव जयते

Smt. Tinoo Joshi
Deputy Secretary

PMP-4597

प्रधान मंत्री कार्यालय
नई दिल्ली 110 011
PRIME MINISTER'S OFFICE
NEW DELHI 110 011

August 2, 1988

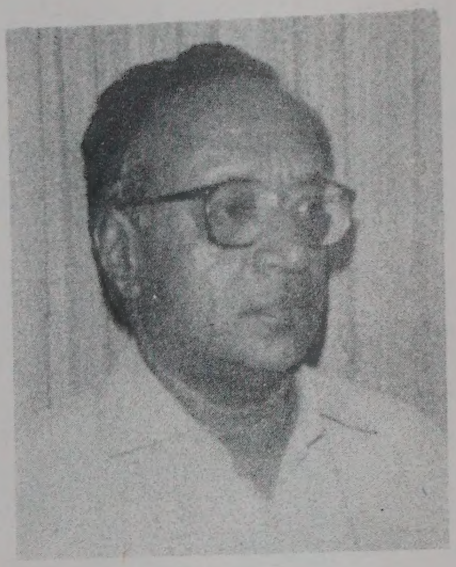
Dear Dr. Ghei,

The Prime Minister sends his good wishes to the Indian Hospital Association, Delhi for a successful International Workshop on Hospital and Primary Health Care being held in New Delhi from August 21-23, 1988.

Yours sincerely,

(Tinoo Joshi)

Dr. P.N. Ghei
Secretary General
Indian Hospital Association
C-11/72, Shahjahan Road
New Delhi 110011



MESSAGE

I am happy to note that Indian Hospital Association in collaboration with International Hospital Federation, Lodon are organising an International Workshop on hospital and Primary Health Care in Delhi from 21st to 23rd August, 1988. The deliberations of the workshop would be relevant and useful in the context of the preparation for the Eighth Five Year Plan. We are looking forward to the recommendations of this Workshop.

I wish the Workshop proceedings all success.

New Delhi.

20.8.1988.

(P.K.Umashankar)
Special Secretary
Ministry of Health & Family Welfare.

W.K.KELLOGG
FOUNDATION

May 26, 1988

Dear Mrs. Ghei:

I wish to greet all of the participants in the International Workshop on Hospital and Primary Health Care as you meet in New Delhi. I commend you for your untiring efforts to improve health care for all. We are delighted to see many new initiatives whereby hospitals are working in innovative ways to provide greater access and improve the quality of health in the areas in which they serve. We urge continued initiatives to involve community people, particularly underserved populations, in the planning and delivery of primary health care. Our experience teaches us that local people have tremendous capacity to improve their own health when they are treated with respect and dignity and institutions build their capacity to help themselves. Best wishes for a successful conference and more importantly, for your follow-up activities.

Sincerely,

Norman A. Brown

Norman A. Brown
President

Warszawa 12.08.88

Pr. dr. med. Tadeusz Tolloczko
chirurg

00-480 Warszawa, Wiejska 9 m. 9
tel. 21-59-48

Mr. President of the Indian Hospital Association
Mr. Chairman of the Organising Committee
Friends and Participants.

I would like to express my great regrets for not being able to attend the International Workshop on Hospital and Primary Health Care, to join scientific sessions and participate in the deliberations on this so important problem you are going to consider.

Just as well functions as morphology of the hospitals have been changing, and certainly will continue to change parallel to the changing role of the hospital in the community. This is the consequence of growing demands and needs, rapidly growing costs and cost constrains.

There is imperative need for thinking and education how to make Health Service continuously more effective and efficient. Society as well as individuals cannot wait too long for the new and proper solutions and decisions. We have to look for factors essential for successful Primary Health Care and Hospital activity. To take right long term decisions it is necessary to think globally and act locally.

Therefore I would like to congratulate Indian Hospital Association for assuming for the next time organisational role of the International Conference in 1985 and this International Workshop, on Hospital and Primary Health Care. May I congratulate you for undertaking, continuing and contributing to this so important in practice problems.

I would like also to take this opportunity to pay a special tribute to Dr. P.N. Ghei for the very important role he plays in the Council of the Management of the International Hospital Federation.

Again I wish to thank Indian Hospital Association for having organised this international event. I am sure it will be just as great success as the Conference in 1985 had been. Accept please my sincere regrets for not being able to attend this venture.

Prof dr Tadeusz Tolloczko
President of the I.H.F.

2 St Andrew's Place London NW1 4LB
Telephone 01-935 9487
Facsimile 01-487 3674

International Hospital Federation
Fédération Internationale des Hôpitaux
Federación Internacional de Hospitales

PHC, TEN YEARS ON

The decade of primary health care has now passed. The achievements in getting more health care to more people, through primary health care have been enormous.

The impact has not only been felt in the developing countries but primary health care concepts are being adopted internationally. The ideas are being incorporated into the new approaches to solving health care problems in big cities of the world.

Hospitals are playing their part in delivering, promoting and teaching primary health care. This especially applies to the district hospital which in many cases now see themselves as a health resource for their total community not just for the patients in their beds.

It is WHO which must take the credit for getting the message of primary health care to health care professionals around the world. The past Director General of WHO, Dr Halfdan Mahler, was a prophet of the new era. His work in this field will be a living memorial for his period as WHO Director General.

IHF has been happy to take a leading role in bringing the ideas and techniques of primary health care to hospitals around the world.
PHC has been an ongoing theme of IHF education programmes and publications for more than the decade of primary health care. IHF will continue to proselytize.

The Indian Hospital Association is to be congratulated on organising the conference on Primary Health Care of which this report is the proceedings. It follows the earlier event which was also a great success.

It is this international and ongoing commitment to primary health care which will bring better health status to the citoyens of this planet Earth!

ERROL PICKERING PhD
Director General

INTERNATIONAL HOSPITAL FEDERATION

L to R : Mrs P. Ghei, Secretary, I.H.A. and KIFPH Fellow, Dr. U. Ko Ko , Regional Director, S.E.A.R.O., W.H.O , Dr. M.S. Nanda, President, I.H.A. and Dr. B.D. Miglani, Vice-President , I.H.A., New Delhi.

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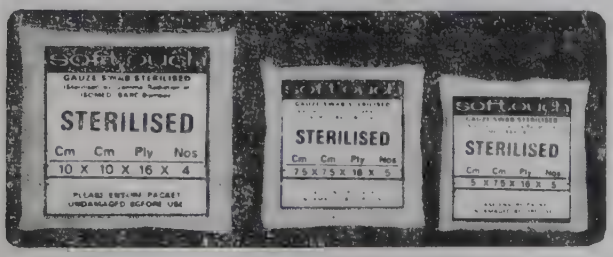

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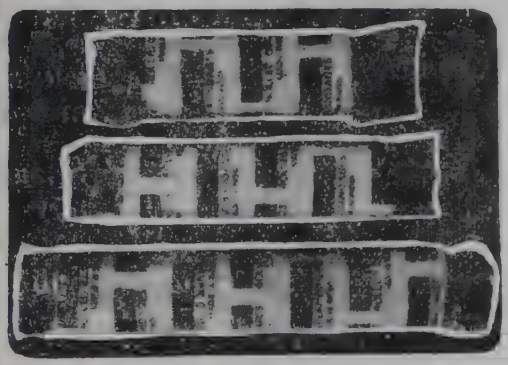

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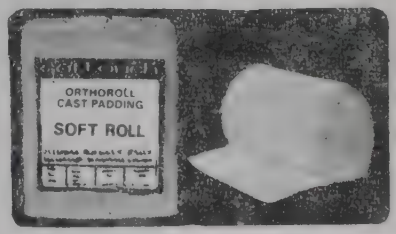

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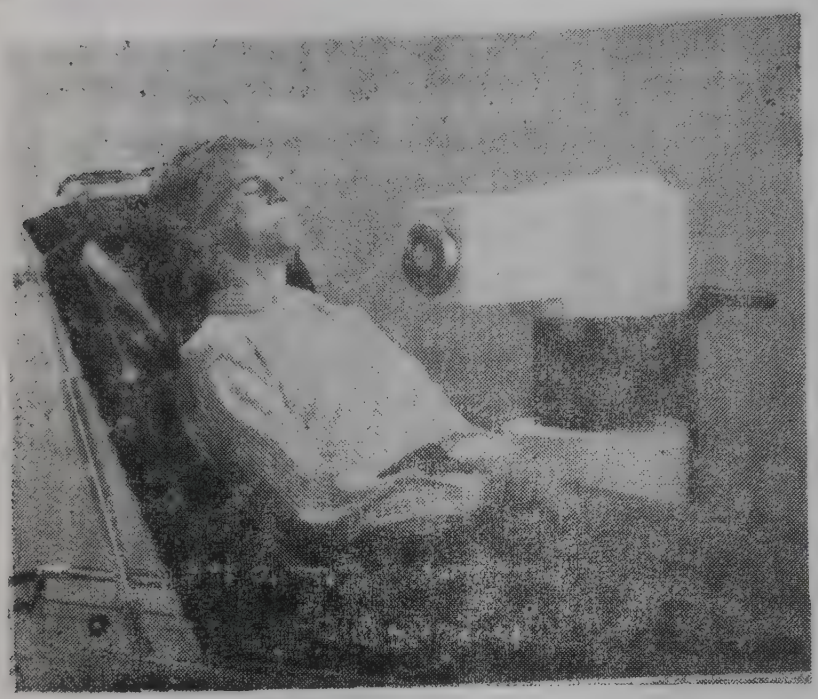

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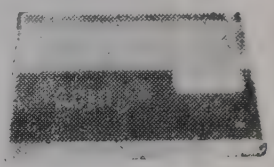

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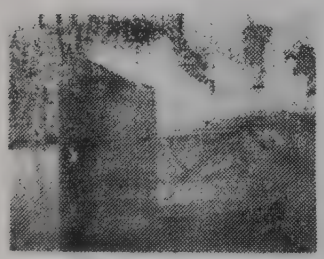

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Application examples:
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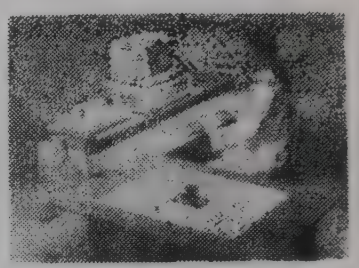
microSelectron LDR $^{192}Ir/^{137}Cs$

Interstitial 15-channel Low Dose Rate remote afterloading system.

Application examples:
Breast, bronchus, cervix, endometrium, head and neck, mouth, nasopharynx, prostate, rectum and many others.



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Inaugural Session

WELCOME	Dr. M. S. Nanda, President, Indian Hospital Association, New Delhi
ADDRESS	(1) Mr. Rolf C. Carriere, Chief Health & Nutrition, UNICEF, Regional Office for South Central Asia, New Delhi
	(2) Mr. Robert A. De Vries, Programme Director, W.K. Kellogg Foundation, U.S.A.
	(3) Dr. Roy J. Gerard Director, Kellogg International Fellowship Programme in Health, U.S.A.
	(4) Mr. Miles C. Hardie Member Steering Committee KIFPH & former Director General, IHF, London
INAUGURAL ADDRESS	Dr. U. Ko Ko Regional Director, World Health Organisation, SEARO, New Delhi
VOTE OF THANKS	Dr. P. N. Ghei Secretary General, Indian Hospital Association, New Delhi.

Welcome Address by Dr. M.S. Nanda

President
Indian Hospital Association

Dr. Ko Ko, Dr. Roy Gerard, Mr. DeVries, Mr. Miles Hardie, Dr. P.N. Ghei, Distinguished Delegates from abroad and India, Members of Reception Committee, Ladies and Gentlemen :

On behalf of the Reception Committee and on my own behalf, I welcome Dr. U.Ko Ko, Regional Director, World Health Organisation, Regional office, for South East Asia, New Delhi who, despite his having arrived from abroad, a few days back, has found it convenient, to be with us, to grace this occasion and to inaugurate this International Workshop. The presence of Dr. Ko Ko at this eccasion and his dedication to the achievement of 'Health For All' is a fact, that all of us know. It is, because of untiring efforts of stalwarts like him, that we do hope, to achieve many targets. set for the Year 2000 A.D. I take this opportunity also, to welcome distinguished representatives, of W. K. Kellogg Foundation, Michigan State University, International Hospital Federation, UNICEF, National and International agencies and distinguished nominees, who are here to take part, during this Workshop. We also welcome, every delegate, from India and abroad, who have responded to our request in such a magnificient manner.

Many of you know, that this International Workshop, is a follow up of 1985 international activity, where after the Conference, we adopted a 'New Delhi Declaration' on Hospital and Primary Health Care. I do hope that distinguished delegates, will have time to discuss and recommend, a suitable 'Declaration', by the end of this three days Workshop.

May I again, extend to you, all a very heartily welcome.

Address by Mr. Rolf C. Carriere

Chief Health & Nutrition UNICEF Regional Office for South Central Asia, New Delhi

This international workshop on hospital and primary health care provides UNICEF with another opportunity to make a small contribution to the momentum of the current global movement beyond medical care to health care. On behalf of the UNICEF Regional Director, Dr. Karl-Eric Knutsson, who could unfortunately not be present on this occasion, may I convey warm greetinge to you, and our good wishes for your success.

It is common, but misleading, to view primary health care as an absolute alternative to conventional medical care. Both are founded in science, but modern medicine, in its actual practice has tended, due to social reasons, to distance itself from the generality of people. Indeed, it is prone to price itself out of popular market.

In response to such a situation, medical practice is often tempted to justify its increasing cost by pursuit of specialisms, with little regard to a holistic concept of health. We believe primary health care has come as a prescription based on this diagnosis. Its role is to build a bridge between modern medicine and human health, between biological sciences and social sciences, in the context of health and development.

We believe that the concept of primary health care is as radical as you wish to make it. We also believe that the principal actors in moving the concept to practice are neither the professionals nor the governments, but the people themselves. This is why we are attracted by the concept of "hospitals without walls", by the possibility of shifting the focus from hospitals and asylums to homes and communities. This translation of concern will not be automatically achieved, given the cultural bias in favour of prestigious institutions, specialized qualifications and gigantic investments.

These precisely are the factors that magnify the artificial distance between the people and tneir seemingly elusive health, between modern medical knowledge and the pattern of much of its practical application. Lately, the issues involved in this distortion have been extensively debated, by and outside the medical profession. And some answers have broadly been agreed upon, and we hope these will be carried further forward by this workshop.

Our perceptions of the present health situation in South Asia may be summed up by two broad observations: On the one hand, while the concepts that govern our approach are reflected in health policies and programmes, the stark indicators of health, especially child

health, remain broadly unyielding in this part of the world. We have to appraise, through a process of introspection, what comes in the way of expected result. On the other hand, there are excellent examples of dedicated effort in isolated pockets scattered through this region where the principles of primary health care are vindicated daily—the proof of the practice being the high levels attained in the health of these small communities. Again, we need to appraise why and how things do work.

It would not be proper for me to go into details, but I would like, even at this stage, to place before you three points for consideration.

— First, we could consider the possibility of resorting to new forms of organizing and delivering health related services by people in low income groups : for example, by upgrading competence and role of the community worker, by concentrating on better organizing and managing our health centres, by reorienting hospitals into referral centres, by keeping over-specialism in check.

— Second, we need to place an emphasis on children, and mothers, as the most productive and cost-effective way to continue and accelerate our work towards health for all, by preventing ill-health, disease and disability where that is relatively the easiest. In the context of hospitals care this means that all patient-contract should also be utilized as opportunities to provide primary, preventive and promotive care.

— Third, we need to seriously consider the far reaching implications of the new findings about the role of mind in caring and healing for the way societies organize their health and medical systems. Our narrow biomedical model and scientific approach, with its positivistic and reductionistic bias, has brought us a long way, but in the process something essential got left out. In a sense, the new evidence about the important role of the state of mind of patient and provider—represents a rediscovery of the perennial wisdom and practice of health, healing and spiritualism in which this country is (still) so rich. It would be a tragedy if this wisdom got lost in our rush to health for all by the year 2000.

On behalf of UNICEF in South Asia, I thank you for the opportunity to share some of our concerns with you. Indeed, we look forward to the outcome of your deliberations.

Address By Mr. Robert A. De Vries

Programme Director
W. K. Kellogg Foundation, U.S.A.

Distinguished officials of the Indian Hospital Association, ladies and gentlemen. It is my honor and pleasure to be part of this important international workshop and to bring greeting from the board, officers, and staff of the W. K. Kellogg Foundation, Battle Creek, Michigan, U.S.A.

The Foundation, established in 1930 to "help people help themselves," has distributed more than one billion dollars (U.S.) in support of programs in agriculture, education, and health. Areas of emphasis within those broad fields include adult continuing education; community-based, problem-focused health services; a wholesome food supply; and broadening leadership capacity of individuals. Projects in opportunities for youth are concentrated mainly in Michigan; support for economic development projects is provided only in Michigan. The Foundation is today among the largest private philanthropic organizations in the world. It supports programs in the United States Latin America, the Caribbean, and southern African countries. Limited worldwide involvement is achieved through international networks of activities related to the Foundation's programming interests.

Over our nearly 60 years of operation the Foundation has been especially concerned with the provision of primary health care and the preparation of health professionals essential to its delivery. Even the Kellogg International Fellowship Program in Health focuses on primary health care and in several ways we have cooperated with national and international organizations including the World Health Organization, Geneva, and the International Hospital Federation, London, in fostering improved primary health services worldwide. As some of you may know we had the opportunity in January 1985 to assist the Indian Hospital Association and the International Hospital Federation in a meeting similar to this : The New Delhi International Conference on Hospital and Primary Health Care. From that international forum came the New Delhi Declaration on Hospital and Primary Health Care which has been influential in asserting how governmental, corporate, voluntary, and private health and human service agencies should work together to achieve to important goals for advancing the health and well-being of all people.

Again, I thank you for this wonderful opportunity to join you and I express appreciation to our hosts, the leaders of the Indian Hospital Association for their excellent arrangements.

Address By Dr. Roy J. Gerard

Director
Kellogg International Fellowship Programme in Health, U.S.A.

Dr. P.N. Ghei, Dr. M.S. Nanda, Mrs. Pramila Ghei, and distinguished members of the Indian Hospital Association.

I consider it an honor that you have invited me and our Kellogg International Fellows in Health to be here today to participate with the Indian Hospital Association in their 25th annual meeting and the International Workshop on Hospital and Primary Health Care.

Attending your conference and workshop will surely improve our knowledge of primary health care programs in India and the efforts that the Indian Hospital Association has been making in extending health care to all in line with the Alma Ata Declaration of 1978.

In 1985 Michigan State University received funding from the W.K. Kellogg Foundation to develop and administer an innovaivte fellowship project in international health.

This program, the Kellogg International Fellowship Program in Health (KIFPH), offers recognized professionals from around the world an unusual opportunity to broaden their experiences, develop international leadership capabilities, and explore new interdisciplinary approaches to health. The program is designed to advance leadership for improving human well-being through community-wide, coordinated, cost-effective health services with emphasis on primary and health management.

The central theme of the KIFPH is the advancement of professional leadership to bring about improvements in primary health care and health management on a global basis.

The Fellows and their projects will contribute to the development of new approaches to promoting human well-being. The projects will also contribute to the strengthening of their sponsoring institutions. Networking among Fellows and institutions will provide more effective sharing of information and ideas for primary health care improvement.

As you know, our KIFPH program began in 1986 with the selection of 29 leaders in primary health care and/or health care management. Through the development of projects, our Fellows have sought to develop new models that may more effectively provide

primary health care. Through various types of networking, our Fellows have been helping each other to learn more. Our networking began with an international symposium at Michigan State University where our Fellows first got to know one another. In September of 1986, our Fellows gathered again for a week in Oxford, England, where we occupied Queens College. This again allowed us to share ideas and also learn about the British Health Care system. In 1987, our group once again gathered in Brazil where our Fellow had helped to arrange a program for us to learn about the Brazilian Health Care system.

This meeting was preceded by a pre-conference in Colombia, where our Fellow from Bogota showed us his project made us an integral part of an international seminar on Health Care in Big Cities. A second part of this pre-seminar took us to Cali, Colombia, where two of our Fellows showed us their projects and gave us a further insight into Colombian Health Care systems.

This year, our major seminar is in China where our six Fellows will help us learn about Chinese health systems. A few days ago a small group gathered in Egypt to learn about a Primary Health Care curriculum in an experimental setting in Ismailia, Egypt. Today, most of the Fellows have gathered here, at your kind invitation issued through our Fellow from India, Mrs. Pramila Ghei. We are indeed honored to be able to be here with you. The program you have prepared looks excellent.

Let me take a few moments now to introduce our Fellows and my staff to you. I would like each of the Fellows to stand up when I mention your name. Dr. Jaime Arias, former Minister of Health and Minister of Education from Bogota, Colombia. His project is using the patch method to bring organized health care together to underserved areas in urban Colombia. Dr. Martin Bass, from London, Canada, is developing innovative approaches to understanding appropriate medical technology.

Dr. Antonio C. Carvalho is from the Federal University of Minais Gerais in Belo Horizonte, Brazil, and is developing a "Problem-oriented Multi-professional Continuing Educational System." Dr. Chen Yu-de is Dean of the School of Public Health at Beijing Medical University. Dr. Chen is involved in the development of a training center for health management at Beijing Medical University. Dr. Chen Zhi Xing is Deputy Director of the Shanghai Ninth People's Hospital and is involved with the Shanghai Second Medical University. Dr. Chen is using the case-study method to design model training programs in hospital management for middle level hospital administrators.

Dr. Carlos E. Climent is associated with the Department of Psychiatry, School of Medicine, University of del Valle in Cali, Colombia. Dr. Climent's project concerns the development of curricular strategies in psychiatry for deprived populations. Dr. Mia Defever is the Director of the European Health Policy Forum with headquarters in

Leuven, Belgium. Dr. Defever is working on the enhancement and consolidation of the European Health Policy Forum as her major project.

Dr. Julio J. Frenk is the Director General of National Institute of Public Health, Ministry of Health in Mexico. Dr. Frenk's project is developing demonstration projects in a number of communities as Mexico expands its primary health care delivery throughout the country.

Ms. Pramila Ghei, who you know well, is the Secretary of the Indian Hospital Association; headquartered in New Delhi, India. The main thrust of Ms. Pramila Ghei's project has been networking and conducting a study of the Interventions of Primary Health Care in Urban Community Interalia Hospitals.

Dr. David S. Geer, Dean of Medicine, Brown University in Providence, Rhode Island, USA, has organized primary care for education at Brown University and has developed a Center of International Medical Exchange Training at his university. Dr. Rodrigo Guerrero is a Professor of Social Medicine at the University of Del Valle, Cali, Colombia. Dr. Guerrero has developed a multidisciplinary program to promote development in health, public services and welfare for Aqua Blanca, a squatter area outside the city of Cali.

Dr. Sagar C. Jain is Chairman of the Department of Health Policy and Administration, School of Public Health, University of North Carolina in Chapel Hill, North Carolina, USA. Dr. Jain's project examines the role of culture on managerial behavior and effectiveness. Dr. Snehendu Kar is the Associate Dean and Chairman of Public Health at UCLA. Dr. Kar's project is designed to develop and field-test indicators of health promotion actions for planning and evaluating primary health care programs.

Ms. Hilda Kigutha is the Head of the Department of Home Economics at Egerton University in Njoro, Kenya. Ms. Kigutha's project has integrated a nutrition component into a primary health eare program in rural Kenya. Dr. David Kindig is Director of the Graduate Program in Health Administration at the University of Wisconsin in the United States. Dr. Kindig has developed new curricular programs for health services management through the creation of case-studies which he has used for teaching.

Dr. Tamar Krulik is the Chairperson of the Department of Nursing at Tel Aviv University in Israel. Dr. Krulik has developed an integrated community care program for children with chronic problems. Dr. Liu Yongliang is the Director of the Department of Medical Services in Technology associated with the Shanghai Municipal Health Bureau. As a Kellogg Fellow, Dr. Liu designed a program to develop a quality assurance system for clinical laboratories.

Dr. Marcus Liveris is the Deputy Vice Chancellor of Health Services for Curtin

University of Technology in Perth, Australia. Dr. Liveris' project as a Kellogg Fellow has two components : 1) the evaluation of the newly established Health Advisory Network, and 2) the use of the network to identify the health promotion and management roles of professionals in primary health care. Dr. Afaf Meleis is a Professor of Mental Health, Community and Administrative Nursing, in the School of Nursing at University of California, San Francisco, USA. Dr. Meleis' Kellogg project involves the assessment of health care needs of populations that are at risk and under-served in developing a health care resource center for immigrant women in the San Francisco area.

Dra. Clara Misrachi is the Director of Dental Education, School of Dentistry, at the University of Chile in Santiago. Dra. Misrachi is developing a comprehensive model, for providing education, preventive measures, and systematic dental services to primary school children. Dr. Zohair Nooman is the Vice Dean, Faculty of Medicine at the Suez Canal University in Egypt. Dr. Nooman's project has focused on the creation of a center for research development in medical education and health service at the Faculty of Medicine at the Suez Canal University.

Dr. Evangelos Petropoulos is currently a Professor of Physiology in the Faculty of Medicine, University of Zimbabwe. Dr. Petropoulos' project focuses on the implementation of a new undergraduate medical curriculum which was developed during his Deanship at the University of Zimbabwe. Dr. Alberto Schwarcz is the Director of the Department of Neonatology, Hospital Zonal Dr. Diego Paroissien in Buenos Aires, Argentina. Dr. Schwarcz has developed a coordinated program in prenatal health care in the low income population of suburban Buenos Aires with the aim of improving the health of mother and child during pregancy.

Ms. Theresia Sri Suhesti is the Manager of the Common Health Services in St. Carolus Hospital, Jakarta, Indonesia. Ms. Suhesti's project has provided a comprehensive and integrated system of health services for the low income and less educated groups in urban areas in the vicinity of Central Java. Dr. Antonio Torrado is a Professor of Pediatrics and medical director of Pediatrico Hospital in Coimbra, Portugal. Dr. Torrado's Fellowship project has prepared, tested and evaluated a protocol for perinatal and child health care.

Dr. Wang DeBing is Vice President of Beijing Medical University and Deputy Director of the People's Hospital in Beijing, China. Dr. Wang is interested in improving hospital administrative efficiency and the quality of health care. Dr. Wang Shaoxian is Chairman and Professor of the Department of Health Statistics and Medical Demography at Beijing Medical University. Her project is entitled "Family Planning, Maternal Child Health Quality-of-Care Demonstration Project." She has integrated family planning into primary services.

Address

Dr. Donald K. White, Head of the Overseas Unit, Health Services Management Center, University of Birmingham England, is working with selected health management training institutions in Africa in an effort to disseminate information about ways in which these institutions have strengthened their impact around quality of health management. Dr. Zhang Mingdao is the Vice Director of the Shanghai Medical Health Center, Shanghai Institute of Health, Shanghai. Dr Zhang's project involves the improvement of the medical health care delivery system in Shanghai at the Municipal, District, County, and local levels.

I want to also introduce my staff. Dr. Herbert L. Whittier my Associate Director is a development oriented medical anthropologist on the project. Ms. Kay Backus, is our Program Coordinator. My assistant Director, David Horner, is in China working on our conference arrangements there and will join us here in a couple of days.

We also have a Steering Committee and several of them have been able to join us for this meeting. Dr. Don Detmer, Vice President for Health at the University of Virginia. Mr. Miles Hardie, already known to you, is well known through his stewardship of the International Hospital Federation. Dr. Gloria Smith is Dean of Nursing at Wayne State University in Detroit, Michigan, and Dr. Carlos Leon is Directer of the W.H.O. Collaborating Centre for Research and Training in Mental Health in Cali, Colombia. Dr. Hanmin Liu, Director of the U.S.-China Educational Institute will be joining us in a couple of days.

Again, it is with great honor that I offer my thanks for the opportunity to be here with you and to speak with you about the KIFPH project. Thank you.

Address By Mr. Miles C. Hardie

Member Steering Committee KIFPH
& Former Director General, IHF, London

It gives me very great pleasure to be asked to say a few words at the start of this workshop, not least because it brings back happy memories of the very successful conference on the same subject that was held here in Delhi in January 1985.

Then, as now, the Indian Hospital Association played a leading role in the organisation and conduct of the meeting, and in doing so it had the support of the Ministry of Health and Family Welfare, the WHO Regional office for South-East Asia, UNICEF and the International Hospital Federation, and I am glad to see all those organisations represented here this week.

In 1985 there was much discussion arising from the international survey on the role of hospitals in primary health care conducted by Dr. Rufino Macagba of the Philippines. This project was sponsored by the IHF and funded by the W.K. Kellogg Foundation of USA. It is good indeed to see here Mr. Robert DeVries, Program Director of the Foundation, because it was he who was largely responsible for the funding of Dr. Macagba's study, and I should like to express my thanks to him for all that he has done to help and support the IHF in this and many other ways. And of course I am delighted that we have here with us so many of the Kellogg International Fellows, particularly as for many of them it will be their first visit to India. Mrs. Pramila Ghei is one of the Fellows; she and her husband and daughters worked hard to make a success of the 1985 conference, and I know they are all very much involved in this one.

Thanks to Mrs. Ghei's Kellogg Fellowship, and to the enthusiasm of so many members of the Indian Hospital Association, hospital/ PHC surveys have spread far and wide through India, with students of health care management actively taking part in their conduct. The question today is no longer *whether* hospitals should be involved in promoting or providing PHC, but *how* they can most effectively fulfil this role. During this week we shall hear papers on this subject from many different countries: I feel confident that you will find this a very interesting and useful workshop, as well as an enjoyable one.

Inaugural Address :

Role of the Hospital in Total Health Care

By Dr. U. Ko Ko*

Mr Chairman, ladies and gentlemen,

Medicine began as an art and, over the centuries, gradually evolved into a science many times overshadowing humanities. In pre-historic times, medicine was intermingled with superstition religion, magic and witchcraft. Since then, dating back to 3000 BC traditional medicinal systems such as Ayurveda, Siddha, Unani as practised in India and Egypt, and Chinese and Korean medicine, became the world's first organized body of medical knowledge. The other great reservoir of medical knowledge during the early middle ages was provided by the Arabs. The great Hospital of Jundi-Shapur was completed in the seventh century AD. Christianity exerted its influence on the establishment of the so-called medieval hospitals. The First hospital on record in England was built in York in 937 AD.

The period following 1500 AD was the dawn of scientific medicine. Towards the end of the nineteenth century, advances began to be made in medical sciences and technology that transformed the activities of hospitals, asepsis, anaesthesia, and later in every branch of medical sciences. The need to control epidemics at the community level, as well as on individual basis, led to the development of public health and community medicine.

Thus, while hospitals provide personal medical care to individuals, the responsibility for taking preventive measures and for dealing with community as a whole was being undertaken by public health organizations and other local health services. The dichotomy of medicine into two major branches, namely, curative medicine, and public health/ preventive medicine, evolved in the seventeenth and eighteenth centuries, was established firmly at the close of the nineteenth century.

After the Second World War, the rate of anvance in medical science accelerated. For many developed countries, this was a period of economic prosperity, allowing sharp increases in health care spending. In developing their national health services, newly independent countries follow the western models of medical education and service and favour high cost, low coverage, elite- oriented health services.

Gradually high technology medicine seems to be getting out of hand and leading health systems away from health promotion and protection towards expensive treatment for the few. Physicians and other professionals were eager to develop and adopt a more

**Regional Director, World Health Organisation, South-East Asia Region, New Delhi*

sophisticated technology that transformed hospitals into even more complex and potent places, irrespective of cost and without sufficient attention to priorities in their local areas. At the same time, community health became the concern of public health organizations only while hospitals confined themselves to the clinical care of the individual.

Global conscience was stirred leading to a new awakening that the health gap between the rich and the poor within countries and between countries should be removed. It is conceded that the neglected majority of the world's population too has an equal claim to health care and health protection and promotion. Against this background, the Member States of WHO pledge themselves, in 1978, to the social goal of Health For All by the Year 2000 using the primary health care (PHC) approach, i.e., attainment of a level of health that will permit all people to lead a socially and economically productive life.

In the Declaration of Alma Ata, it is clearly stated that PHC should be sustained by an integrated, functional and mutually supportive referral system, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need. HC relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers including village health workers as applicable, suitably trained and oriented to work as a health team and to respond to the expressed health needs of the community. Thus hospitals and other local health services must share the responsibility for individual care at home, in the community and at the first contact and referral levels.

In the context af integrated health care, with primary health care as the key approach, the most important practical level for detailed examination would be the district health system. A district, because of its strategic location, is a compact, well-defined peripheral area which serves as a vital link between the community and the secondary and tertiary levels of the centre.

A district health system comprises first and foremost an area with a well-defined population living within that clearly-delienated administrative and geographical area, whether urban or rural. It includes all institutions and personnel providing health care in the district, government, social security, non-governmental or private. A district health system, therefore, consists of a variety of inter-related elements from health and other related sectors that contribute to health. It includes self-care and organized health care and health workers and facilities, including the health centre and hospital at the first referral level, with appropriate laboratory and other diagnostic and logistic support services.

Hospitals thus constitute an integral part of the health delivery system providing integrated and comprehensive PHC action programmes to the whole district. It has the

responsibility for total health care within a specified geographical area and defined population - the district. The hospital, as a community health centre, could coordinate and collaborate with other health services and health-related sectors in the district in the delivery of PHC action programmes to the communities within the district.

The hospital's contribution can be in the form of morbidity and mortality information, resource allocation and control, intersectoral action for health, manpower development and deployment, procurement of supplies and other logistic support. The hospital may house the district health system where all health and health-related sectors are represented.

Hospitals should, therefore, be shifting their emphasis to community based and problem-oriented service, taking part in the delivery of PHC action programmes and not confined themselves to individual clinical care. Good examples in this context will include health education, nutrition, maternal and child care including family planning and immunization, and disease control programmes, covering all aspects of health care -- promotive, preventive, curative and rehabilitative.

Hospital-Based patient referral systems and outreach programmes often do not function satisfactorily. Patients sent direct to the hospital are often referred by the first-level health facility, physician, or other health worker but very often the patients are not received properly, or arrive after considerable delay because of financial or logistic problems. Feedback to the referring person or institute for continuing care is lacking or inadequate. These problems and issues should be remedied and address, to develop an effective two-way referral system.

The hospital, as an institute concerned with the health of the community, would greatly strengthen promotive and preventive health activities by, for instance, serving as a base for continuing education and training, both professional and non-professional. In this way, the highly qualified staff and resources of the hospital influence positively on the health situation of the community. In order to help clarify the health needs in the communities it is vital that field workers be prepared to collect and transmit appropriate data for timely analysis in the hospital. This would help the hospital to better orient its activities so that they can contribute more effectively to meeting the needs of the community.

The hospital, with its professional experience, is well placed to contribute to training for better community health, both by practice of community health and by giving training to a range of health workers, in the community, for field work and service in other peripheral health institutions. Volunteers can be trained and oriented to work in the hospitals or in community health projects. Women's groups and other social groups can be organized to take part in PHC action programmes among the community. The support

services to these health facilities in the network are not limited to only training and supervision but also include the two-way referral system and exchange of information. The same may also be applied for the control of communicable diseases as well as non-communicable diseases. Thus the hospital and the health facilities in the system can form an effective network for the prevention and control of highly important problems in the communities.

Some of the areas of competence in hospitals based on the primary health care approach are emerging with increasing clarity. Promotion and application of community participation in the planning and operation of community-wide health activities in coopperation with primary health care services outside the hospital are needed. Leadership role from hospitals is required for many of the health plans and programmes from the community that involve cooperation from other sectors. Community leaders have to be identified, trained and developed for collaboration with hospitals in developing the district health system.

In order to improve the scientific and technological aspects, the hospitals, depending upon their resources and competency, should be involved in basic as well as applied research. Health systems research to examine ways to a better understanding of health problems in the communities, in identifying innovative measures and appropriate technologies, and for improving the health service delivery systems are of practical importance. Epidemiological research on the collection of prerequisite data needed for good health planning process, and clinical research directly related to day-to-day needs are some other examples.

In conclusion, I would like to pay a tribute to the Indian Hospital Association, who, alert to the changing trends in the health system, have organized this important international workshop. Due to time constraints and realizing the fundamental importance of the most peripheral-level delivery system for community, I have confined myself to hospitals in the district health system. Also, I have not touched upon the importance of the scientific basis of clinical medicine since this aspect has been amply covered on many occasions. I sincerely hope that the important role of hospitals of higher echelons and apex bodies in their academic competence and technical leadership position vis-a-vis peripheral hospitals of district hospital may be discussed during this workshop or at a later time.

And, finally, I would like to express my gratitude to the Indian Hospitals Association and the organizers of this workshop for giving me the opportunity to be amongst this distinguished gathering and share my views with them.

Thank you.

Vote of Thanks

By Dr. P. N. Ghei*

Dr. U. Ko Ko, Mr. A. De Vries, Dr. Gerard, Mr. Hardie, Dr. Nanda, Distinguished KIFPH Fellows, Members of Reception Committee, Ladies & Gentlemen;

Before I present the vote of thanks I will like to read out some of the Messages (messages read). The next I will like to share with you the background of this International Workshop which is a follow up on the International Conference on Hospital and Primary Health Care (PHC) which was held in New Delhi in January, 1985 and the document caption 'New Delhi Declaration on Hospital and PHC' was evolved. One of the recommendations of this International Conference was to review the 'New Delhi Declaration of 1985' in a suitable forum at periodic intervals. In this Workshop, we have circulated among your documents 'New Delhi Declaration on Hospital and PHC' and we will discuss the same and may be coming up within an updated Declaration of 1988. In this Workshop we have representatives from different disciplines and, therefore; it is truly multi-disciplinary.

A request I will like to make to distinguished participants, ladies and gentlemen as to treat this Workshop as **'No Tobacco—No Smoking'** Workshop.

It is now my pleasant duty to propose a vote of thanks to Dr. U Ko Ko, Regional Director WHO, SEARO, New Delhi for agreeing to deliver the Inaugural Address and kind enough to inaugurate this Workshop. His address will remain a trend setter for years to come on this important subject of Hospital and PHC. I am also thankful to the other distinguished colleagues in the WHO, SEARO, New Delhi Office for contributing towards the success of this workshop. I am thankful to Mr. Robert A. De Vries of Kellogg Foundation for attending this workshop and thanks for his address. Much more wisdom will follow from him when he delivers Dr. B.L. Kapoor Oration tomorrow. Dr. Roy J. Gerard, Sir, I have special thanks for your presence and address. Mr. Miles C. Hardie has been with us earlier and he is closely associated with Indian Hospital Association since 1983 in the development of long term project of Hospital and Primary Health Care when he was the distinguished Director General of International Hospital Federation, London, U.K. We owe him a special thanks and we intend to honour Dr. Roy J. Gerard and Mr. Miles Hardie tomorrow by inducting them as Honorary Life Members of the Indian Hospital Association, New Delhi.

To the Government of India, Ministry of Health and F.W., we owe our gratitude without whose encouragement, help and guidance this Workshop would not have been a success as distinguished participants not only from all parts of India but also from other countries of abroad are attending. I will personally like to thank Mr. Uma Shankar, Special Secretary, Ministry of Health & P.W., New Delhi, for his kind help.

I will be failing in my duty if I do not thank my colleagues particularly the Patrons, Dr. M.S. Nanda, Dr. S.D. Vohra and Pramila who worked very hard for the success of this Workshop.

Secretary General, I H A, New Delhi

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Key Note Address Session

CHAIRPERSON

Dr. S.D. Vohra,
Chief Rapporteur and Chairman
Scientific Committee
International Workshop on Hospital and
Primary Health Care,
New Delhi.

ADDRESSEES

(1) Hospital and District Health System
Dr. Sombhong Kutranon,
Regional Adviser on Community Health Services,
World Health Organisation, SEARO,
New Delhi (India)

(2) Urban Health Care (UHC) interalia Hospital and Primary Health Care (PHC)
Mrs. P. Ghei,
KIFPH Fellow and
Secretary, Indian Hospital Association,
New Delhi (India)

(3) Family Beds Health Services in Shanghai
Dr. Chen Zhixing
Deputy Director
Shanghai Ninth People's Hospital
Shanghai Second Medical University
Shanghai (China)

Hospital and District Health System

By
DR. SOMBHONG KUTRANON*

It has now been universally accepted that the global strategy of Health For all cannot be implemented on the massive scale required through central action alone. Therefore attention is called to the need to approach solutions through manageable units. These manageable units can be called by any name but for the purpose of general understanding they were called districts. Therefore the focus on district health systems came to the force.

Some feeling that the seeming antagonism between hospitals and primary health care is false for no hospital could claim that they would not serve health for all and that hospital involvement is essentially for primary health care whichever way one looked at it. It continued by indicating that hospitals should not only be concerned with individual patients and acute curative care but should also have a responsibility for restorative, preventive, promotive and rehabilitative health care for a defined geographical area. In particular, the hospital at the first referral level, which is not necessarily synonymous with but can also be represented by the district hospital, should be integrated in a district health system and function as a full partner with other health-oriented institutes and groups for the benefit of all.

There are a few countries where the responsibility for all elements of the district health system is the sole responsibility of one governing body or authority. More often, the district health system is composed of a mixture of government, health insurance, voluntary, private and industrial health organizations, and activities are undertaken at various levels of service delivery and care, ranging from civic groups involved in the promotion of training in simple health issues, the provision of care at the level of the community health worker, health posts at the level of health centres, public health activities in district health offices and more complex invasive treatment in district hospitals. Therefore without effective coordination amongst all these agencies, an effective and efficient action for primary health care is likely to be limited and the health priorities for the local population likely to be determined by the goals or interests of individuals and institutions rather than the need of the community.

Even in situations where the total health system is under government control, this is usually run from the capital and often involves a number of government programmes, the

*Regional Adviser on Community Health Services, WHO/SEARO, New Delhi

coordination of which, at local level, is frequently absent. Often these government programmes are out of step with each other and moreover, programme management for health may be fragmented and scattered amongst different sectorial authorities or, even within the health sector, programme managers, with a resulting waste, conflict and detraction, and less impact than is possible or required.

In addition, there are the inherent differences in the history, philosophy and way of working of the hospitals, and the other elements and services that constitute a district health system. Often activities in the hospital are focused on an individual approach, sophisticated technology and intensive treatment aiming at quick results. Professional control and dependence of the patient, on the other hand, are traditionally activities at the other primary health care levels of service delivery, focused on populations as well as individuals, on simple methods of prevention and treatment, and are more long-term oriented. People are required to be self-reliant and less dependent on providers. But the common ground of health for all implies a close collaboration, if not integration of both types of activities, and therefore a review of the orientation of hospitals from high technology and doctor-interest to community need.

Existing for centuries as institutes to care for the sick, needy, infirm, aged or wounded, hospitals underwent an enormous growth and change with the advances in technologies. Starting in the latter part of the last century, hospitals changed a great deal from a care into a cure institution, which stimulated a particular outlook, organization and management. Until recently a "central" notion dominated ideas concerning the role of hospitals in the health care system. The hospital was considered the centre providing leadership and guidance to all other forms of health care and the medical approach very much determined the shape of national health systems.

Over the past twenty years there has been increasing dissatisfaction about the relevance and effectiveness of these national health systems in developing and industrialized countries. The highly sophisticated and very costly medical technologies usually concentrated in hospitals were seriously questioned in the light of its social relevance and effectiveness for the health of people.

People became aware that physicians were not the only human resource to be used in all cases, hospitals were not the only way to provide health care, and the medical was not the only possible foundation for a national health system.

As a result the world community recognized the alternative approach of Primary Health Care involving the totality of all potential resources and based on equity and justice, individual and community self-reliance and intersectoral cooperation, including community involvement, would promote and achieve in a faster and more efficient way the goals for Health For All.

In this philosophy and approach as embodied in the Declaration of Alma Ata of 1978, the hospital came to be seen as a part of wider health system. Primary Health Care constitutes the foundation and the role of hospitals is to support it as a referral and back-up mechanism. This shift in position in the world's perception, made many hospitals and professionals uneasy, but provided together with other socio-economic imperatives. the impetus to both the public and private owner and operator to re-examine the position of hospitals with respect to Primary Health Care.

Hospitals are traditionally concerned with individual patients in a one-to one relationship, usually for curative care by professional manpower using costly high technology and defining quality and effectiveness in terms of individual care. Primary Health Care advocates promotive and preventive activities apart from treatment, seeking to deploy all available resources to meet all essential health needs through the use of appropriate technology, para-professionals and community health workers. It defines quality in terms of effective improvements in the health status of populations, equity, self-reliance and area-wise coverage.

Initially, often perceived by many health professionals and administrators as competing concepts in the organization of health care, there is increasing recognition that although from different origins and heritages, hospitals and Primary health Care services serve a common purpose, that of Health For All. Whether or not a hospital offers support for Primary Health Care can probably best be recognized by examining its role in their local situation.

In several countries, hospitals have been experimenting with integration in local health systems. Strong support has come in different forms and the following examples of approaches and practice may illustrate the above.

1. **Direct government involvement**

The Government can be the main body for initiating the hospital reorientation programme on the basis of analyses of the local situation and agreement among the various components of the health system.

2. **The creation of health council where parts of the district health system are controlled by different government and non-government bodies**

A council could be created to coordinate health services delivery and to stimulate other action to protect and promote the health of the whole population of the district. Such a council would be likely to include representatives of the local community, the central government, financing agencies, voluntary organizations, hospitals and other health services.

3. Creation of a district health management team

In a similar situation to the one above, where parts of the district health system are controlled by different owners and operators, health professionals and managers from the community, including the hospital, could be appointed by a central or local government to act as a management team to coordinate health services in a defined area.

4. "Contract" between hospital and other health care providers

Another approach to integrating the components of a district health system that belong to a range of different government bodies, is to make a mutual agreement : "Contract". More specifically, a contract between the hospital and other health care providers, together with some mechanism, of which the community would be a part, to monitor and enforce the agreement, would provide an alternative approach to integration at district level.

5. Designation of a non-government hospital to coordinate primary health care

In those areas where a strong non-government hospital would already be present, and government service weak or absent, this hospital could be encouraged to develop and support the other levels of service delivery for coordinated action. Several examples can be cited for this type of development where church-related hospitals account in some countries for 50 to 60% of rural medical and health care. Many of these hospitals we e pioneers of primary health care and experimented with outreach programmes and community health departments long before official recognition was forthcoming. In some places they assist the local production of essential drugs, link up with traditional medical workers and help to solve community health problems.

6. Legislation and Regulations

A number of countries have attempted to effect integration of health care systems through legislation and central regulation. In varying degrees, legislation for both practical and ideological reasons has been attempted in many others, ranging from the Chinese Ministry of Health Decree that every hospital must have a public section, to the decision in Yemen and Tanzania to establish PHC units and, in the Philippines, which entrusted over all responsibility for health care in some provinces to their provincial hospitals.

Problems of Attitudes, Reorientation and Training

Next to the problems of an organization and functional nature, serious problems or obstacles to implementation were identified in the area of attitude reorientation and training. People often have an over glamourized view of hospitals and may be ignorant of the capabilities and benefits of their local primary health care facilities. This attitude

may be enforced by the insular inclination of institutional professionals. In general it is unfortunately true that individual medical care is often better tewarded than that of preventive and public health services both in the established government remuneration system and in the public's perception. And so both financial reward and social recognition mitigate in favour of incidental individual care rather than activities leading to health for all.

In order to reorient this unfavourable development, it is necessary that the hospital actively support the other institutes and levels of care in its area. In doing so, better service will be provided in the whole area by all concerned, including the hospital, which will then be better able to concentrate on those activities which it can best perform.

Some approaches to solution might be

a) **Changing attitudes**

Resistance to change should not be considered only as a negative factor but an inner strength that, if properly harnessed, could be used to promote the interdependence of community and hospital services to further change within established institutions. A policy of active liaison with primary health care services should be developed that would lead to the recognition of each other's strengths and weaknesses in order to develop a better collaboration.

b) **Redefining roles in service and education**

If the hospital can come to be perceived both by its staff and the community as an institute concerned with the health of the community and not just as a disease oriented organization, its capabilities would greatly strengthen promotive and preventive health activities, by for instance, serving as a basis for continuing education and training, both professional and non-professional In this way the highly qualified staff and resources of the hospital will have an additional beneficial influence on the health situation of the community.

c) **Information Collection**

In order to help clarify the health needs in the communities for the hospital staff it would be vital that field workers have the training and ability to collect and transmit appropriate data in time for analysis in the hospital together with hospital information. This would help the hospital to better orient its activities so that they contribute more effectively to the total coverage of needs in the community with appropriate care.

d) **Community health training**

The hospital, with its concentration of professional experience, should be well

placed to contribute to training for better community health, both by promoting community health and by giving actual training to a range of health workers, for the community, for field work and service in other peripheral health institutions, as well as giving recurrent training to its own and other staff.

e) **Defining Effectiveness**

Increasingly it has become necessary to express the hospital's significance in terms of relevance for the community rather than the classical hospital indicators expressed in numbers of beds, occupation rate, infection rate. etc. We should therefore be looking for performing indicators that would express the hospital's effectiveness with community-oriented care rather than unrelated technology.

f) **Incentives to change**

None of the above initiatives will have any impact unless change is promoted and appropriate incentives are provided. As indicated previously, remuneration, both in the official as well as the collateral market, goes a very long way towards influencing the health system's activities but also social recognition and non-cash rewards have proven to be of invaluable support to the reorientation of attitudes and the orientation of attitudes and the orientation of workers and services. It should be recognized that although social change is a long-term process, the information is overdue.

One among the most important roles of hospital in the district health system is preferred support. In considering the problems of referral systems, the following key problems can be identified.

1. The overloading of a particular facility with inappropriate self-referrals or poorly judged referrals.
2. Problems of distance, transport and payment.
3. Lack of confidence in the health centre and health post levels and the by-passing phenomena leading to problems of the first type.
4. Inadequate flow of information amongst facilities, lack of logistics and maintenance support.

In considering solutions it should be recognized that :

(a) the whole referral system, covering all levels of service delivery from family, community, health centre activity up to the hospital, should be viewed as an integrated system;

(b) a referral system cannot be developed otherwise than in consultation with all providers and partners as well as the potential consumers participating.

(c) it is of the utmost importance to ensure regular and close contact between the elements of the health system, including the hospital, so that staff know and have confidence in each other;

(d) it is equally important to avoid the rigid procedures which by their lack of options would condemn a referral system from its inception.

From another point of view, consideration should be given to the referral system attuned to specific patient referral as opposed to the referral of administrative and management problems. In the first category some important issues are the following :

1. Ensuring that the hospital effectively function as a referral centre for the district and does not become bogged down in activities that can be carried out at other levels.
2. Referring patients back as soon as possible with appropriate treatment and full information to the source of referral.
3. Implementing some incentives and disincentives to support the proper use of its referral services. For instance, charging a fee to patients that have referred themselves unnecessarily, versus providing full information and, where necessary, other support to the properly referring sources.
4. Making referral easy and convenient by providing for instance, well designed forms in sufficient quantities to referral sources.
5. But, most important, developing manuals and clear instructions and procedures for referral.

Concerning the referral of administrative and management prablems an important area of collection and mutual support would lie in :

- the supervision of logistic support to peripheral health centres, health posts or community health workers;
- encouraging intersectoral collaboration in order to tackle the health problems over a broad frontline by including local departments of agriculture and education, as well as church-related health services;
- contributing to the development of appropriate training and supervisory mechanisms for all health workers, including traditional birth attendants and healers.
- involving hospital staff in the education of other health workers;
- the development of mechanisms for evaluation of the various main components of the referral system,

Annexure I

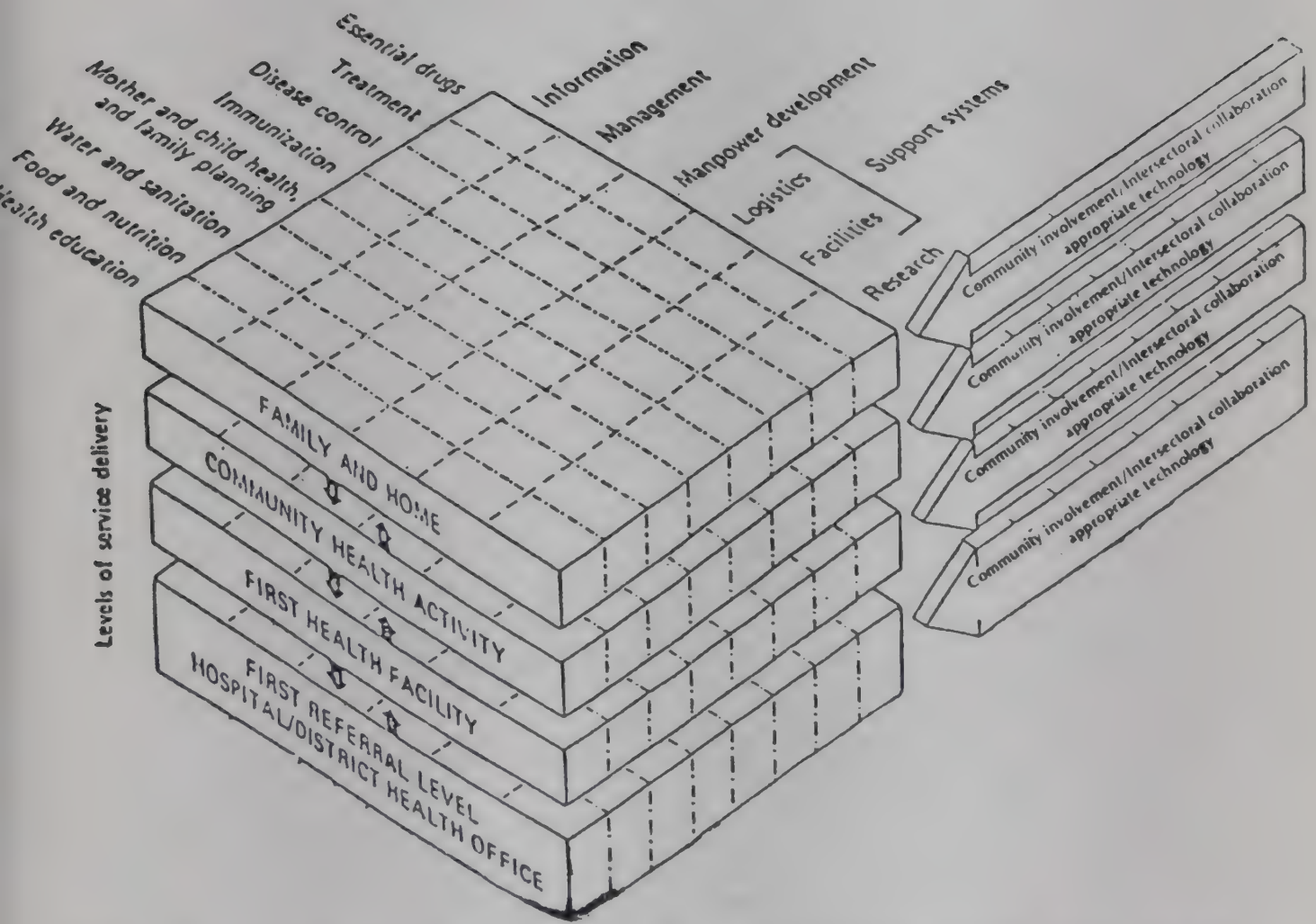

FIG 1. Representation of the components of a District health system based on the strategic principles of Community involvement, Appropriate technology and Intersectoriaj collaboration.

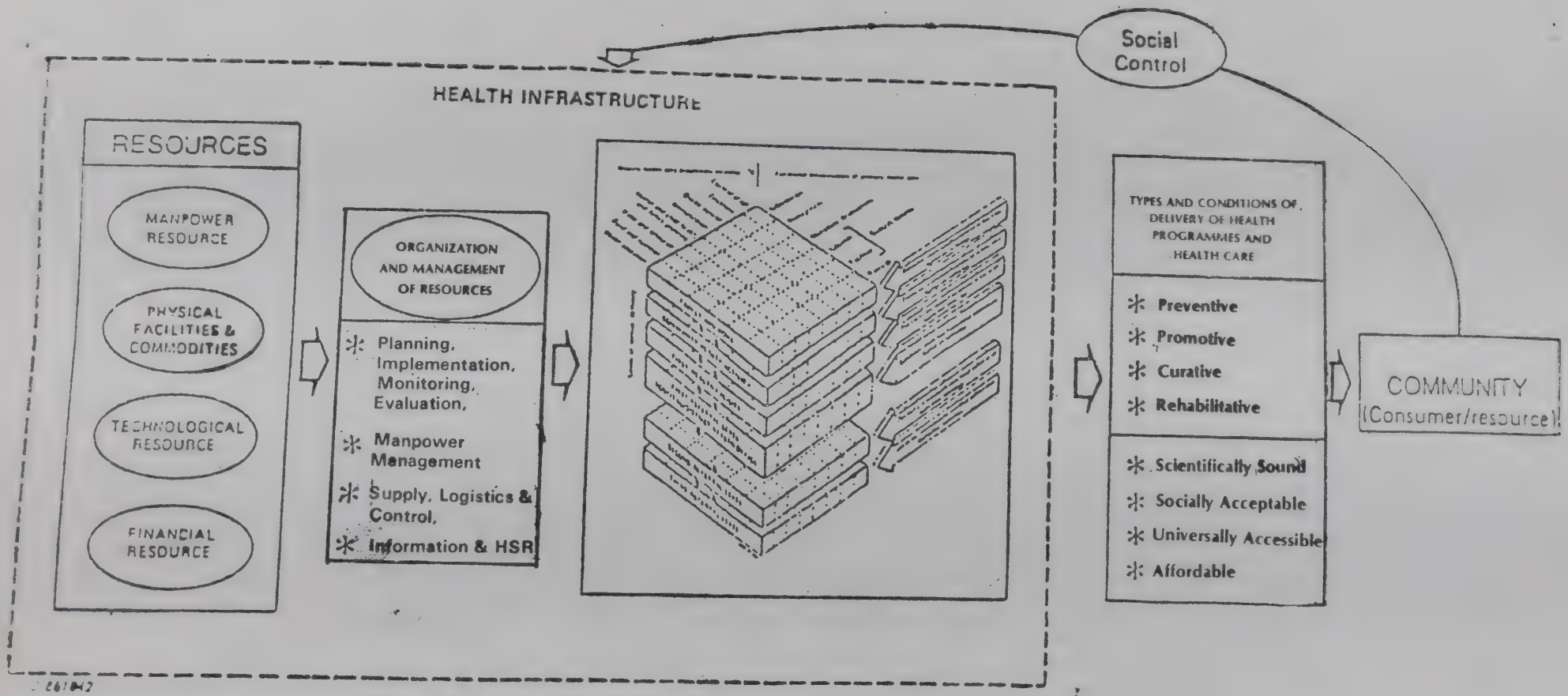

FIG 2: Components of a comprehensive health system based on PHC

Primary health care programme elements
Functional intrastructure of primary **health care**

Urban Health Care (UHC) Interalia Hospital and Primary Health Care

*By Mrs. P. GHEI

The Indian Hospital Association (I.H.A.) has been closely watching developments on the national and international scene in the field of Primary Health Care. This interest was intensified following the historic Declaration of Alma Atma in 1978, and its adoption by the World Health Assembly in 1979. This set the target of 'Health for All' by the year 2000 (HFA 2000), and the members-states of the World Health Organisation committed themselves to this goal, identifying PHC as the very factor in achieving HFA 2000. At the annual convention of the IHA in Delhi in December, 1981, a session was held on the role of hospitals in HFA 2000. This attracted a large audience, and the proceeding were published in the IHA official Journal 'Hospital Administration (Vol. XVIII, No.4). In August, 1982, Dr. U. Ko Ko, Regional Director of WHO South East Asia Region who inaugrated workshop this morning delivered the Dr. B.L. Kapur Oration on the subject of 'Medical Care For HFA by the year 2000. In his speach, Dr. U. Ko Ko said, "It is gratifying to see that the Government of India has already initiated steps in this direction but, ladies and gentlemen, I would stress, that it would be highly desirable for the IHA to join the Government in achieving this object." In January, 1983, Mr. Miles Hardie, the then Director General of the International Hospital Federation. London, visited Delhi who is with us in this workshop. After giving a lecture on "The role of hospitals in PHC" (subsquently published in Journal 'Hospital Administration Vol. XX Nos. 3 & 4), he had discussions which led to the IHA deciding to consider the idea of conducting a survey of all 65 hospitals in Delhi to find out the extent to which they were involved in promoting, supporting and providing UHC. This proposal was discussed and approved by the IHA Executive Committee in February 1983 under the Chairmanship of Dr. M.S. Nanda, President of IHA. The eight components which are included in Primary Health Care are :

1. Education of people about prevailing health problems and methods of preventing and controlling them.
2. Promotion of food supply and proper nutrition.
3. Adequate supply of clean drinking water and basic sanitation.
4. Maternal and child health care and family planning.
5. Immunisation against major infectious diseases.
6. Prevention & control of locally endemic diseases.

*Secretary, I.H.A. & K.I.F.P.H. Fellow, New Delhi. and Dr. P.N. Ghei, Secretary General I.H.A. (Read by Mrs. P. Ghei)

7. Appropriate treatment of common diseases & injuries.
8. Provision of essential drugs.

Initially many national and international authorities considered Primary Health Care as a parallel approach to the existing health services. However, it was realised that hospitals have a pivotal role to play in primary health care in terms of rendering the Primary health care; supporting primary health care, providing training in primary health care as also the important role in logistics and supplies. In order to sharply focus the role of hospital in primary health care, an International Conference was organised by the Indian Hospital Association, New Delhi, International Hospital Federation, London with the support of W.K.Kellogg Foundation, USA and with the knowledge of the Ministry of Health and Family Welfare, Government of India, New Delhi and World Health Organisation, South-East Asia Regional Office New Delhi (India). This Conference was attended by 240 distinguished participants from 24 different countries of the World in which practically all the regions of the World were represented. This was organised in January, 1985. Among the important recommendations which emerged and which took into consideration the National Health Policy of the Government of India which was evolved in 1983, a set of recommendations now popularly called the New Delhi Declaration on 'Hospital and Primary Health Care' was evolved. The important feature of this Declaration are as under :

1. Emphasis has not to be on whether hospitals have a role in the Primary Health Care but how hospitals can become fully involved in the practice of Primary Health Care.
2. In order to promote Primary Health Care, ten priorities emerged :
   i) The formulation of a health policy centred on primary health care.
   ii) The development of the health infrastructure with special reference to referals.
   iii) The development of sensitive indicators.
   iv) The identification of appropriate technology.
   v) The development of health manpower.
   vi) The education & training of all categories of staff.
   vii) Community involvement.
   viii) Development of a suitable health information system.
   ix) Optimisation of financial support and the maximisation of scarce resource.
   x) Monitoring and periodic evaluation of outputs and programmes to effect corrective steps.
3. All agencies—governmental, corporate, voluntary and private must work together towards the achievement of pre-set goals and targets, in time.

4. Progress in the implementation of Primary Health Care should be renewed by a suitable forum at specified intervals.

The hospitals are directly involved in all elements of PHC except water supply, sewerage disposal. In order to quantify the role of hospital in Primary Health: IHA undertook a project initially as already stated in all the 65 hospitals in Delhi and later on to other hospitals in different States of the country. For the purpose of this study, the standardised questionnaire was evolved after discussion and pretesting questionnaire on the table. The important aspects of this study which I intend to share is no non-response by 65 hospitals in Delhi. An innovative methodology was used by using Post-graduate students in programmes of health and hospitals administration in the city of Delhi. This not only made the job of the hospital authorities responding to questionnaire easier but also gave practical training to the students and the IHA got all the hospitals responding to the questionnaire. For the study of all hospitals outside Delhi the same questionnaire was used but the methodology used was Seminar participants to various Seminars conducted by the IHA both in and outside Delhi. The results of 65 hospitals studied outside Delhi were compared. This constituted the first phase of the project. International Hospital Federation made a token contribution of £ 500 for this phase: The analysis of both studies of results of first phase of survey show that practically every hospital is involved in some form of PHC, and some of them in a wide range of PHC activities. But although more hospitals are more involved in PHC than many people expected, it is equally clear that more hospitals could do more, the publication of the results of the survey encouraged more hospitals to become more active in this respect, and also give useful guidance and practical examples of ways in which they can set about doing this.

In general the survey proceeded smoothly and their was good cooperation from virtually all of the hospitals. This could be attributed to a number of factors.

a) In the hospitals of Delhi there is already increasing interest in PHC and a more widespread awareness of the hospital's responsibilities in this field.

b) The survey was seen as a non-threatening exercise.
The hospitals did not feel they were being inspected by outsiders coming to look for faults; on the contrary they realised they were being asked to describe and discuss what they thought they were doing well in relation to PHC.

e) The use of postgraduate students as information-gatherers relieved the hospitals of much of the detail work of completing the questionnairs, which made them all the more willing to cooperate in the survey.

d) The hospitals realised that the publication of the results of the city-wide survey could be of practical help to them in their own efforts to promote, support or provide PHC.

From the viewpoint of the schools of hospital and health administration; the use of postgraduate students for this survey also produced benefits :

i) It helped to orientate the students towards the importance of the hospital's role in PHC.

ii) It provided valuable training experience for them in hospital/PHC development.

iii) It likewise provided useful experience in survey methods, use of questionnaires and report-writing.

iv) It gave the schools as extended range of contacts with all the hospitals of delhi.

The survey of PHC continued subsequently through the grants of using KIFPH Fellowship when I was selected for the same in 1986. Thus the project entered its third phase. This phase constituted survey of larger samples of Hospitals outside Delhi through the Seminars methodology and covering whole of Kheda District (Ufban) -UHC in Gujarat. District Kheda has 75 Hospitals in urban area and we studied 66 hospitals. Other than Hospitals in Delhi and District Kheda the number of hospitals in urban area studied till 31st May, 1988 are 250.

The study of Hospital's role in UHC interalia PHC has resulted in the following tangible benefits:

1) This has acted as a catalytic for the increasing role of hospitals in PHC like hospitals taking more interest in Immunisation, Health Education, Deaddiction Clinics etc.

2) The use of PHC approach in delivery of Health Services has made an impact on child survival by way of lowering of Infant Mortality rate (IMR) which now is 95/1000 live birth as National level, though some States has as low as 50/1000.

3) The survey has provided good case study material for use in various courses in Health/Hospital/Community Health Administration and or Management.

The results of the survey show that practically every hospital is involved in some form of PHC, and some of them in a wide range of PHC activities. But although more hospitals are more involved in PHC than many people expected, it is equally clear that more hospitals could do more; so it is hoped and intended that the publication of the rerults of the survey will encourage more hospitals to become more active in this respect, and will also give useful guidance and practical examples of ways in which they can set about doing this.

In general, the survey proceeded smoothly and there was good cooperation from virtually all of the hospitals. This could be attributed to a number of Factors :

a) In the hospitals of Delhi, District Kheda and others, there is already an increasing interest in PHC and a more widespread awareness of the hospital's responsibilities in this field.

b) The survey was seen as a non-threatening exercise. The hospitals did not feel they were being inspected by outsiders coming to look for faults; on the contrary

they realise that they were being asked to describe and discuss what they thought they were doing well in relation to PHC.

e) The use of postgraduate students and Seminars participants as information-gatherers relieved the hospitals much of detailed work of completing the questionnaires, which made them all the more willing to cooperate in the survey.

d) The hospitals realised that the publication of the results of the survey could be of practical help to them in their efforts to promote, support or provide PHC.

e) The survey revealed an active interface between hospitals and PHC.

The next phase dovetailed with the rest of the project was to study indepth of Child Survival interventions and the following write up has been developed. This developed on the basis of study of PHC in District Kheda. The undertaken studies were :

1. Growth Monitoring

Hospitals have already created feeling that proper growth of a child is dependent upon 'tonics' and 'Powder milk'. Fortunately, demand for formula milk appears to be declining. However, Doctors, Nurses, and hence people have not given up the old habit of chasing 'tonics' unnecessarily. Hospital can work in the area to dispel such notions. Similarly, Health Workers should be trained to spread nutrition education. With the help of suitable approach like use of Road-to-Health Card, the community can be made aware of physical development of the growing children. If this is backed upon with referral services which in turn is supported by hospital, the task becomes easier. Physical well being of the child also depends on the ante-natal clinic. Again, hospital can train Health Workers to take care of pregnant women and identifying high risk group for prompt referral. Similarly, health workers can be trained in dealing with common illnesses in children and identifying high risk children for prompt referral.

2. Oral Rehydration

Hospital can spread awareness about oral rehydration therapy, through the health workers. Particular emphasis should be on early institution of CRT and continuation of the feeds to the child. If hospital down plays the role of medicines in common diarrhoea, people will accept ORT more and more. Unfortunately, most of the doctors still prescribe meaningless medicines in diarrhoea. Another tendency in the doctors and nurses is to mystify the ORT by using different brands. The General hospital should promote a simple home based methods for ORT. Hospitals can go on for vigorous awareness drives before the diarrhoea season, remind people, in time, of the virtues of ORT (Oral Rehydration Therapy).

3. Breast Feeding

Breast feeding should be positively promoted by the hospitals. It starts from the hospital wards. Instead of providing the much needed support to the mother who has just delivered, often easy way is sought out for. This can prove to be a disaster for the young child. Breast feeding is not simply taking the child to breast after birth, pregnant

mother should be informed of the advantages of breast feeding and of colostrum right in advance. If health workers are taught all these they can motivate women to start breast feeding soon after delivery. Health Workers should also be taught how to deal with sore nipples, retracted nipples etc. as also manual expresson. How material nutrtion affects the breast milk qualitatively and quantatively and also psychological aspects of breast feeding should be clearly explained to the Health Workers. If hospitals can disseminate such information the traditional support system in our well knit society will be of a great flourishing ground to strengthen the feeding behaviour of the society. It is necessary also to cultivate proper wearing practices using locally available foods. Often illness in the child is attributed to 'defects' in mothers's milk. Again, such notion should be dispelled by spread of proper information.

4. Immunisation

That immunisation is a great leap towards bringing down the childhood mortality is established beyond doubt. Presuming that regular supplies of vaccines are available, one needs to concentrate on possible bottlenecks. Cold Chain maintenance equipment and injection technique, logistics and community acceptance are the most critical areas in these regards. And thus proper adminstration is the key to efficient running of immunisation programmes. Proper knowledge of six vaccine preventable diseases should be imparted to health workers. Only then superstition can be removed and community acceptance can be improved. Qualitative aspects like proper Cold Chain maintenance right up to the most peripheral posts, proper sterilisation and injection techniques, stress on motivating people to get their children immunised will considerably enhance the credibility of the programmes. Again these are the areas where hospitals can provide input. Often, in chasing the targets, these qualitative aspects are over looked. There is no need to intensify immunisation programmes, at the expense of other important aspect which can only be learnt with experience. The Immunisation Mission level is the right approach.

5. **Health Education**

Active participation by the people and their englightened involvement in the programmes are amply demonstrated. It was stressed to increase knowledge but identified that major achievements have only been possible through 'Learning by doing' method. The field workers under professional guidance demonstrate the various techniques to the commmunity and then keep on repeatedly observing and correcting these. They reported that most of these newer concepts and methods were easily understood by the community and were being used extensively. The main thrust has been to popularise the scientific methods by co-relating these with prevalent practices, briefs and values. The exclusive use of media like Radio, T.V. etc. is again step in the right direction,

6. Child Spacing

To achieve target of Nett Reproductive Rate (NRR) of one (Unity) by the year 2000, following interventions are being undertaken :

1. Natural Family Planning methods (Rhythem and Coitus Interruptus).
2. Condoms—conventional contraceptives—Nirodh and Jelly
3. Oral Pills—Mala D.
4. Copper T—intrautrine device (IUD)—Tambi.
5. Sterilisation of male and female i.e. Vasectomy and Tubectomy—Nasbandi.

The approach has been till recent years levying more stress on terminal methods of sterilisation rather than reversible methods—spacing methods—of sterilisation Newer contraceptives are also making inroads in efforts to control population like Norplant (subdermal implants) and Nonoxynol Vaginal (Today) contraceptives—woman condom. The spacing methods need to be given more attention particularly for females within the age-group of 15-29. The legislative approach has not yielded the desired results in terms of raising the age of marriage etc. and, therefore, certain package had been developed called "beyond family planning". This package consists of raising the age of marriage particularly for the females to minimum of 18, female literacy, development of facilities for women employment, adult women education, increasing enterpreneurship etc.

Another intervention which needs to be mentioned is the establishment of post-partum centres and facilities for providing Medical Terminal of Pregnancy (MT) under MTP Act of 1971. These centres provide facilities to women who are at that time highly motivated to accept the advice of family planning. It is hospital based-maternity oriented approach for the women to accept family planning methods either terminal or spacing after delivery.

Using the primary health care approach to restructure the health care delivery services a huge effort has been made by the country to provide the infrastructure in terms of sub-centres, primary health cares and community health centres in the rural areas, improvement of district hospitals and in the urban areas through family welfare centres and health posts. In this, we have successfully adopted the patch work approach for the rural community by having a sub centre in the area for a patch of 5,000 population; for a patch of 30,000 population a primary health centre and for a patch of 1,20,000 a community health centre. These norms are relaxed for providing this infrastructure in case of hill areas, deserts, difficult areas, tribal population etc. where they are relaxed to provide sub-centre for 3,000 primary health centre for 20,000. The observation beds are added numbering 6-10 at the PHC while the first level referral centre is the community health centre with 30 beds providing coverage in discipline of medicines, surgery, obstetric, gynaecology, paediatrics with support service of anaesthesia, laboratory,

radiology etc. A strong bias towards PHC in the community and at the institutional level. Similar infrastructure in the urban area has not developed as much as was required and the coverage of urban slums, the urban poors, the urban population of Jhuggi-Jhaunpri colonies are no-where satisfactory. An attempt has been made recently based on the recommendations of the Krishnan Committee (1982) to provide health posts of different patches of population—the smallest patch of being 5,000 and next patch of 10,000 and the 3rd patch of 25,000. Such a scheme has been implemented in number of cities in the country. IHA is currently involved in patch work project in the city of Ahmedabad and will be discussing this report in Manila in September, 1988. For manning these infrastructure; the country has made tremendous progress in terms of training of different personnel and here for a patch of 1,000 in rural community a traditional birth attendant (Village Dai) has been trained and a Village Health Guide (VHG) has been trained. Female health worker is stationed at sub-centre alongwith male health worker for a patch of 5,000 population. The Health Assistant, male and female are similarly trained to provide supervisory position and are stationed at the Primary Health Centre alongwith other nursing, paramedical and medical staff. Similarly staff is positioned in the urban patches of health posts and urban family welfare centres. We were fortunate that to have human resource of doctors available (127 medical colleges) despite the brain-drain but we certainly had lot of problems in mobilising the doctors from urban to rural area. We have now less than 10% vacant position in rural areas for the medical officers. Through these health man power army both in rural and urban areas the community is being provided PHC services. The infrastructure detail is Annexed in Annexure I and the developing referral system is shown in Annexure II.

The constraints which have been noticed in UHC interal Hospital and PHC needs to be mentioned and they are :

The foremost constraints and impediments in PHC implementation which have been noticed, is the "forgotten factor" of population explosion and rapid urbanisation. India has achieved remarkable infrastructure for both hardware and software as already discussed but the achievement get diluted as a result of population explosion. Intense and time bound efforts are being made so that population explosion is controlled. Another constraint in India is based on the historic constitutional reasons as health perse is a State subject, though, most of the Primary Health Care activities are founded through Central Plan budget. At times, the State Government do not give that such importance as the centre will desire them to do so.

The other constraints which are equally important and need to be tackled which have been noticed are as under :

i) Inter-sectoral coordination.

ii) Leadership development.

iii) Quality Assurance.

iv) Inadequate communication.

v) Lack of community participation.

vi) Lack of professional managment.

The aforesaid contraints have been identified and number of reme dial steps are being undertaken both by the Voluntary Organisations like IHA, VHAT, IMA and the Government. These problems are met at all levels i.e. grass-root level - Village, Block, District, Regional Levels, State Level and even at national level. It must be mentioned that achievement of 'Health For All by the Year 2000' through PHC approach needs coordinated efforts not only by authorities of health sector but also other sector like Agriculture, Nutrition, Communication, Social Welfare etc. and, therefore, coordination needs to be achieved right from village level to the nation level. The most important tool which is not being extensively used for inter-sectoral coordination and intra-sectoral dialogue is the use of trans-sectoral approach through Committee spectrum. Coupled with these inter-sectoral coordination is the question of leadership development because we have to make efforts to develop leaders who can take challenging decisions, give proper orientation and guidance and ensure political commitment. One of the problems in implementing population control programme is not adequate political commitment coming forward. For the leadership development the political, socio-economic and religious leaders have to sit with professional leaders who have managerial and technical competence so that population control programme is voluntarily accepted by all sections and ethnic groups in the community. The next important impediment which again is of fundamental nature and is being seriously tackled is how can we contact millions of people who need to have H.F.A. message. In order to give practical shape and to accord highest priority. India has taken to implementation very seriously and is taking shape in form of technology missions etc. technology mission for immunisation, drinking water supply and literacy.

The additional constraints in the delivery of primary health care in the urban community particularly in towns, cities and metropolis are posed as a result of urbanisation and industrialisation coupled with the city pull phenomenon which creates major health problems for the urban areas. Lack of housing and basic sanitary facilities has lead to creation of shanty towns, jhuggies and slums with over-crowding, insanitation, lack of privacy and paucity of resources to meet these added demands on the existing health services. In these groups of population mingling of different sections, cultural groups from distant geographical areas makes the problem more complex and difficult.

It is hoped that through restructuring of the health delivery system in the country based on primary health care approach, the country will be able to look after the minimum needs in health sector of all the population and the ideas embodied in the National Health

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Policy of 1983 and the New Declaration of 1985 have changed the approach realising the crucial role that the hospitals play in it and will play in the year 2000. It stands clear that there is an intense interface between hospital and primary health care. This interface is so strong that more and more hospitals are being involved in more and more primary health care. It is also true that more and more primary health care agencies are also looking to hospitals for support, logistics, guidance cooperation, research etc.

It is hoped that the present International Meet will review the New Delhi Declaration on Hospital and Primary Health Care and give a fresh call, provide direction and guidance not only for India but probably the rest of the World particularly the developing countries.

I acknowledge the assistance provided by my colleagues in Indian Hospital Association particularly the Scientific Committee members—to mention particularly—Dr.A.C. Khokhar and Dr S.D. Vohra. I am also grateful of Mr. Miles Hardie for continued support and help. To Dr. R J. Gerard and Mr. Robert A. DeVries for support for the Project. The assistance rendered by the students and Seminar participants is appreciated for the collection of data from hospitals in Delhi. I am also indebted to the various hospital authorities in Delhi for permitting the students to collect the data.

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MANAGEMENT SEMINAR OF MEDICAL RECORD SCIENCES FROM 7TH TO 9TH SEPTEMBER, 1989

The Indian Hospital Association is organising the 1989 Management Seminar for Medical Record Sciences from 7th to 9th September, 1989, in New Delhi. The Seminar is open to the staff working in Medical Records Department of Hospital and other Health related Institutions and others who manage and have collateral relationship based in hospitals, dispensaries, polyclinics, diagnostic centres and other working on various programmes in the Community Health, Rural Health & Primary Health Care. The exact Venue of the Seminar will be informed to the Registered participants in due course.

In this Seminar, Managerial and Techno-managerial skills will be imparted and the subjects proposed to be covered are :—

Management Principles;
Hospital Statistics;
Hospital Organisation Development;
Management by Objective;
I.C.D. and Certification of cause of Deaths;
O.R. (Operation Research) with emphasis on problem solving;
Medical Audit;
Legal Aspects of Medical Records;
M.I.S.
Computers and Medical Records.

YOU MAY SUGGEST, IN CASE, YOU DESIRE TO DISCUSS ANY OTHER SUBJECT(S)

Faculty for this Seminar. will be drawn from Indian Hospital Association, Christian Medical Association of India, YMCA Institute of Management Studies, Ministry of Health & F. W., All India Institute of Medical Sciences, New Delhi, Lady Hardinge Medical College Hospital & Associated Hospitals, New Delhi, Batra Hospital and M.R.C. New Delhi etc. etc.

Participation Fee is Rs. 400/- per participant and the same also be sent in favour of Indian Hospital Association. In case, the payment is sent by an outstation cheque, then bank clearance charges Rs. 10/- may also be added.

Family Beds Health Services in Shanghai

DR. CHEN ZHIXING

Shanghai is the bigest City of the People's Republic of China, which is situated in the east of China. Shanghai, China's No. 1 industrial base and commercial center, is also an attraction to tourists with its numerous historic sites and monuments of ancient culture. It is going to make itself equal to the title of a modernized part city of New China.

Shanghai has a total area of 6185 Square Kilometres, Covering 12 districts and 10 counties, there are 495 hospitals with 54,733 bed, 45 specialized centers for prevention and treatment, 32 hygiene and epiaemic prevention stations, 36 MCH ccnters and 143,454 medical and health professionals in Shanghai, which serve 12,160,000 Shanghai residents and some patients from the other parts of China, thus, the improvement of primary health care in the Shanghai is of urgent importance.

Most developing countries experience shortages of physicians, hospital beds and health care services resources. To overcome the problem, and raise the health status of all their citizens, not only government but also to develop any different Comprehensive primary health care, during these years, in Shanghai, family beds health services are rapidly becoming a preferred methods of providing health care to a large segment of our population, there are 36,000 family beds in 1987.

Family Beds Health Services—Definition

Family beds health service is characterized by health care services professionals to bring health care services to patients in their own homes, hospitalization can often be prevented and residential health care facility placement can be delayed or averted, the availabil!ty of home care services can be particularly valuable to the Chronically ill elderly but can also assist persons of all ages who suffer from acute as well as chronic health problems. There is a growing recognition that family beds health services must be an integral part of the health care system.

Family Beds Health Services—Function

(a) Treatment (including combined traditional and Western medicine)

(b) Prevention health education or Health promotion

(c) Health care (including rehabilitation)

Deputy Director Shanghai Ninth People's Haspital, Shanghai Second Medical University Shanghai, China

(d) Medical consultation

Family Beds Health Services—Administration

Family beds health services system in Shanghai urban area is composed of community hospital health station and the district health bureau, which serves as the Surpervisory body for primary health care and responsible for formulating health programs and plans, examining these plans, according to location, these different level health care service intitutions including teaching hospitals have a close network each other.

Family Beds Health Services—Benifit

(a) To reduce hospitalization rate

(b) To reduce eost of treatment

(c) Take care by family in any time

(d) Convenience for the patients at their home

Family Beds Health Services—Hospital

(a) Consultation

(a) Organization case discussion

(b) Organization case discussion

(c) Priority for admission

(d) Training for family beds health services practitioners

21-8-88

Scientific Session I

CHAIRPERSON

Mr. Miles C. Hardie
Member, Steering Committee and
Former Director General,
International Hospital Federation,
London (U.K.)

SPEAKERS

(1) Five Steps to Primary Health Care -
The critical contribution from hospitals
Dr. Jon E. Rohde,
Senior Adviser, Health & Nutrition,
UNICEF,
New Delhi (India)

(2) Review of the Changed Role Played by Hospitals in Promoting, Supporting and Providing, Primary Health Care in the State of Maharashtra, India
Dr. S.M. Bhadkamkar,
Joint Director of Health Services, (Medical),
Maharashtra, Bombay (India)

(3) Facts to be considered in the Planning of oral health services
Dr. Clara M. Misrachi
School of Dentistry
University of Chile,
SANTIAGO

Five Steps to Primary Health Care

The critical contribution from hospitals

Dr. JON E. ROHDE

While the extensive literature on primary health care suggests an extremely wide array of activities and components, it is possible to identify those activities and services which, if applied to entire populations, could result in a maximal impact in terms of reducing both disease and death. For many populations, particularly those living in urban areas, hospitals provide the only reliable source of primary health care. Understandably, these institutions are called upon to deliver a wide range of services and, in the process, the apparently more simple actions classified as 'primary' are often neglected. Where all hospitals to take measures to assure adequate provisions in the areas of immunization, rehydration for diarrhoea, encouragment of breastfeeding, attention to the early growth of children and the importance of birth spacing through appropriate advice and service in family planning' major strides in primary health care could be assured. The resulting reduction, both in deaths as well as in illness would be a major contribution, but perhaps of even greater interest, this small constellation of programmes could result in large cost savings and a reduction of hospital expenditures.

1. Immunization offers one of the most important technological advances of this century to each and every child. And yet, exit interviews show a majority of children leaving hospital premises have not even had their immunization status checked, and more alarming, the services are simply not available at most times in routine paediatric outpatients and departments. The provision of routine primary immunization services at all hours of outpatient functioning, plus special hours designed for convenience of the surrounding population should be a first priority for hospitals.

Exit checks should be conducted to be assured that every child leaving the hospital is fully immunized. Medical staff should be reminded that there are no contra-indications to immunization. A child who is well enough to go home is well to go home immunized. Great emphasis is should be laid on checking immunization cards in all paediatric outpatient services and children referred for up-to-date immunization prior to leaving the hospital premises. With the availability of refrigerators in the paediatric outpatient, vaccines can readily be stored and given on demand throughout the day. Volunteer groups can be used to screen patients as they leave and send back those not immunized.

Senior Adviser, Health and Nutrition, UNICEF, New Delhi

Special clinics on evenings or weekend days may be opened with particular attention to making immunization more available. This could be combined with outreach information through sound tracks or voluntary groups such as Rotary who would alert underserved areas of the population to the availability of these services. Large banners and signs throughout the hospital should promote immunization, making the population well aware that this service is available.

Government of India policy makes vaccines available free-of-charge so that this service can be done at minimal cost. The goal of universal immunization for children by 1990 is only two years away. Hospitals can make a major contribution to achieving this important societal goal.

11. In many hospitals diarrhoea is the first or second most common cause of consultation and in the monsoon season, diarrhoea patients occupy one-third or more of paediatric beds. The recent experience in Delhi dramatically illustrates the importance of this illness and the means in which it can overwhelm hospital facilities. Unfortunately, urban populations, and particularly the medical profession, seem to forget all too often that oral rehydration, ORT, was specifically designed for the clinical management of cholera and that it is appropriate, effective and affordable even in the midst of large epidemics.

The most efficient way of dealing with diarrhoea is through an outpatient service where a small physical area of the outpatient is set aside for mothers to rehydrate their own child with ORS. An ORT unit can be operated by a low-trained nursing aid, or even a volunteer who simply encourages the mother to feed the child ORS while the child is sitting on a bench waiting to be seen by the doctor. In most cases, rehydration is rapidly accomplished, the mother learns how to perform under the encouragement of the nursing aid, learns how to make ORS from a packet or other means being promoted by the hospital, and by the time she sees the doctor, feels much more confident of herself and recognizes that this therapy is indeed effective. Only the most severe cases require admission.

In hospitals where such units have been introduced in India, admission rate has been reduced by as much as 80 per cent, expenditures on intravenous fluids have been reduced by as much as two lakhs in a year, and the use of anti-diarrhoeal medicines and antibiotics, almost invariably contra-indicated, has plumetted. Setting asides a small area where mothers can rehydrate their own child under guidance is an important contribution of hospitals, both to the spread of knowledge of the importance of ORT, as well as to the reduction of hospital costs associated with necessary hospitalization with intravenous fluids, unnecessary drugs and antibiotics. ORT is a cost-effective, scientifically sound and modern way of dealing with diarrhoea. Every hospital should promote it.

11. Malnutrition underlies almost all disease and yet it is rare that we deal effectively

with anything except the most severe cases. If such infant is provided with a weight card and weighed regularly when he comes to the clinic, or has any other contact with the health system, early faltering of growth can be detected and the mother can be demonstrated improved ways of feeding her child. In addition, and of considerable importance to hospitals, a growth record enables the doctor to visually see whether the child is recovering from illness and whether effective interruption of the cycle of repeated illness and malnutrition has been accomplished. Only if original weight is achieved can an episode of illness be considered fully cured.

Even the trained paediatrician cannot see the subtle changes in weight which contribute to malnutrition with each infectious episode. But anyone, even an illiterate mother, can understand the curve on the growth card and see when it is faltering, see when the child must be fed more, and indeed see that in spite of recovery from acute illness, he may still be classified as sick. Weighing scales should be available in each paediatric clinic; the child weighed and his graph plotted in front of the mother before the doctor sees him. Each paediatric or general medical officer should be encouraged to consult the weight chart and discuss it with the mother upon any interaction. Only this way can the close relationship of malnutrition to underlying disease be remedied effectively. Hospitals must lead the way to break the infection malnutrition cycle.

IV. Perhaps the biggest responsibility of hospitals and the one so frequently neglected is the encouragement of early initiation and sustenance of breastfeeding for all new-born infants. No organizations have had such a detrimental effect on the healthy, normal practice of breastfeeding than organized medicine and, particularly, hospitals with obstetrical units. The clear superiority of breastfeeding as a means to nurture child, for its anti infective properties, and for maternal infant bonding, as well as economies to both hospital and family, are beyond question.

Today,it can be clearly and unequivocally stated that rooming-in is the only reasonable means of caring for a new-born infant with his mother. Nurseries for normal children are today things of the past and should not be tolerated by any hospital administrator.

All hospitals should conform to both the letter and spirit of the International Code on Marketing of Breastmilk Substitutes, not only by refusing to accept advertising, milk nurses or any other form of promotion from infant feeding companies, but more importantly to actively discourage use of bottles and actively encourage breastfeeding within the hospital. In the delivery room the child should be put immediately to the breast to establish not only early breastfeeding and use of colostrum and maternal-infant bonding, but also for the proven reduction in blood loss associated with third phase of labour. Continued frequent breastfeeding throughout the hospital stay should never be

interrupted with top feeds or any other form of nipple-fed supplement. A new-born child is entirely capable of gaining his full fluid and nutrient needs from his mother's breast and it has been well demonstrated and any effort to provide additional fluids is detrimental.

In India today nursing homes providing obstetrical services often require that a mother bring a bottle and infant formula with her when she comes to deliver. This places the child at a 5-8 times higher risk of mortality than he would otherwise be at exclusive breastfeeding. Such maternity home recommendations are patently unethical and should be considered a gross violation, not only of infant food marketing code, but also of the obligation of the institution and the doctor to provide best advice and guidance and the mother. I am certain that all members of the International Hospital Association will respect the importance of encouraging breastfeeding, actively discouraging any use of the bottle and making rooming-in the universal norm for obstetric care.

V. There are few means more effective to preserving the health of mother and child than the appropriate spacing of births. Extensive studies throughout the world have now demonstrated that the close sequencing of pregnancies results in higher mortality of both children as well as the mother. No institution is as respected and is as important in the hospital in convincing the mother of the importance of accepting an effective means of family planning in order to delay her next pregnancy. For the sake of the mother, and of the child, this advice should be provided to every women during ante-natal care and before she leaves the hospital in the post partum period. Additionally, obstetric and paediatric services should remind mothers of the importance of taking necessary precautions with modern methods to protect themselves and their child from the dangers of frequent pregnancy. Hospital post partum programmes have shown a great service in this important regard. Family Planning is good health—all should promote its understanding and acceptance.

While there is no question that none of these five activities are simple, it is clear that among the services provided by hospitals few are as cheap or cost-effective. Every modern hospital should be proud of the important role they take in primary health care and by providing these five critical services to the population can be assured of a maximal contribution, both to the health of the community, as well as a containment and reduction of the costs associated with hospitalisation. I count on all the members of this workshop and of the International Hospital Association to carry this message for wider than the few people at this conference. Only with your active support, encouragement and, most specially, your creating of proper models in your own hospitals can the promise of 'Health for All' ever be realised.

Review of the Changed Role Played by Hospitals in Promoting, Supporting & Providing PHC in the State of Maharashtra, India

BY

DR. S.M. BHADKAMKAR*

Our country is a signatory to the Alma-ata declaration of 'HEALTH FOR ALL BY 2000 A.D.' and therefore, we are committed to achieve this goal by end of the century. It has also been accepted that the approach to achieve this goal is through Primary Health Care. The Primary Health Care is defined as an essential Health Care which should be available within easy reach at an affordable cost and in delivery of which the community participates.

Though the Community Health Centres (Rural Hospitals), Primary Health Centres and sub-centres have a greater role to play in the delivery of Primary Health Care, Hospitals cannot afford to remain aloof. On the other hand they have a very definite and important role to play in promoting and supporting and also providing Primary Health Care. As the Primary Health Care also includes the availability of proper referral care, hospitals have a very important role to play as far as this aspect of Primary Health Care is concerned.

The State of Maharashtra has given a serious consideration to this role of the hospitals during last 4-5 years and have taken a number of steps to closely associate them with the delivery of Primary Health Care as follows :

1. To upgrade the faculties and facilities to enable them to render prompt and adequate referral services at the institution;
2. To extend specialist services to the rural areas by :
   i) Adopting Health Centres in rural areas,
   ii) Regularly holding surgical and diagnostic camps, etc.
   iii) Forming lady Medical Officers' Teams for visits in rural areas.
3. To provide training facilities to the Medical and para-medical staff from rural health infrastructure engaged in the delivery of Primary Health Care.
4. To take the responsibility of supervision and implementation of Primary Health Care and other programmes in urban areas of the district.

*Joint Director of Health Services (Medical), Bombay

5. To utilise hospitals as effective centres for Health Education for patients and their relatives.
6. To implement the National Health Programmes.
7. Conduct training programmes in Health for the community.
8. Undertake opidemiological surveys, operational research projects, etc. to learn more of the community, its health, social needs, economic conditions, etc.

(1) Prompt and Adequate Referal Services

No doubt the primary objective of every hospital should be to render proper, prompt and adequate referral care at an affordable cost and with a human touch. In order to make this care upto date, introduction of new techniques of diagnosis and treatment should be introduced by every hospital so that the patient gets the advantage of modern knowledge and amenities. In our State, there has been a massive expansion of rural infrastructure in particular and also of urban to some extent which will be evident from the following :

S. No.	Type of Institution/ Category of staff	No. as on 1980	No. as on 1987	% increase
I. (A)	**Rural Infrastructure**			
	Rural/Cottage Hospital	85	277	325
	Primary Health Centres	428	1530	359
	Sub-Centres	3391	9238	272
(B)	**Urban Infrastructure**			
	District Hospitals & Women Hospitals	27	33	122
	District Hospitals & Women Hospitals Beds	11317	13451	118
II.	**Man Power**			
	No. of MMHS Class I	609	825	135
	No. of MMHS Class II	1600	4404	275
	A. N. Ms.	4562	9538	209
	Health Guides	9590	44170	460
	Trained Dais	13571	45560	335
	M.P. Ws. (Male)	6000	7851	130

From the above figures, it will be soon that perhaps ours is the first State which has achieved the ratio of the Primary Health Centre for 30,000 on the basis of 1931 population and has nearly achieved the target of one sub-centre for 5000 population.

Due to above massive expansion of rural infrastructure and man power, close and continuous contact with the people by health staff has increased resulting in very large number of referral cases coming to the hospitals for specialised treatment. In order to meet the requirements of the referral services adequately and promptly, following steps have been taken :

a) 284 posts of Hon. Medical Officers are sanctioned.

b) 129 additional posts of Assistant Hon. Medical Officers (OPD) have been sanctioned.

c) 210 posts of full time Class I specialists are sanctioned.

d) It is proposed to create another 140 posts of full time Specialists in following 15 specialities :

1. Medicine
2. Surgery
3. Paediatrics
4. Obst. & Gynaec
5. Ophthalmology
6. Radiology
7. Skin & V.D.
1. Tuberculosis
9. Orthopaedics
10. Anaesthesia
11. Pathology
12. Psychiatry
13. E.N.T.
14. Dentistry
15. Forensic Medicine

The specialists appointed in the hospitals have been fully supported by sanctioning necessary staff and equipments. During the last 4 to 5y ears, 3000 additional posts have been created for hospitals and equipments worth Rs. 200 lakhs have been supplied. Diagnostic Services, viz. Laboratory and X-Ray have been upgraded. The State is aware that only District General Hospitals will not be able to cope up with the tremendous work-load of referral cases and therefore, it has already established 277 community health centres having 30 beds each where the first level referral services will be available. Most of these centres are manned by Class I specialists and assisted by the Medical Officers with post-graduate qualifications and have started functioning satisfactorily.

Training of hospital staff in special techniques :

In order to improve the referral facilities, the State has realised that there has to be

intensive training programmes for the senior staff of the hospitals and accordingly steps have been taken, e.g. a team of Gynaecologist, Pathologist and Laboratory Technician from each of the 33 hospitals were trained in the technique of collection and examination of PAP Smears during June to August 1987 and this facility was started in all the 33 hospitals by and of December 1987.

In order to have early diagnosis of Cancer and also to provide better diagnostic facilities, general surgeons. E.N.T, Surgeons, Gynaecologists are being trained in batches at Tata Memorial Hospital, Bombay in endoscopy and in a phased manner fibre optic endoscopes are also being purchased. It is also under consideration to depute senior general or orthopaedic surgeons for training in trauma care at recognised hospitals like Sion Hospital, Bombay.

Thc State has also taken one more historic step in right direction by issuing in Feb. 88 a Government Resolution increasing the existing hospital fee charges which were framed as long back as in 1957. Till then, most of the hospital services were free and therefore, its value was not realised. Fees levied can be afforded by most of the patients and there are sufficient provisions to treat the genuine cases free. Increase in fee rates will simultaneously raise the resources which will be ploughed back for the improvement of the concerned hospital only. Initial public resistance is now on decline.

(2) Extension of specialists services :

(i) **Adopting Centres** : Every District Hospital has adopted one rural institution in the district where specialists visit regularly and render referral services.

(ii) **Organisation of the Camps :** However, as the field visits by specialists to the adopted centre has got limited scope, it has been decided to hold large number of surgical and diagnostic camps to extend referral services to the remaining rural population.

The increase in some of the referral services through camps is shown in the following table :

S. No.	Type of Camp	Performance in 1980-81	Performance in 1986-87	% Increase
1.	Cataract	10,922	2,05,000	187
2.	I. U. D.	37,909	4,21,000	1.0
3.	Sterilisation	3,11,877	5,50,000	176

(iii) **Forming Lady Medical Officers' Team :**

Recently 200 teams of Lady Medical Officers have been formed in the State. Each team pays about 12 visits to rural institutions in the district every month to render following services :

a) Examination and treatment of Obst. & Gynaec. cases,

b) Training, insertion and follow up of IUD cases,

c) Laparoscopic Sterilisation, etc.

Such a massive extension of specialists services has been feasible only because a fleet of 145 Ambulances and 1200 jeeps was added during the last 4 to 5 years, thus more than doubling the vehicular strength of the State.

(3) **Hospitals as Training Centres**

With such a massive and rapid expansion of Health infrastructure and with the involvement of Nurses more and more in the IUD programme, the expansion of training facilities was inevitable. Uptill now the training of the health staff was carried out mainly through :

(i) 4 Health and Family Welfare Training Centres and Central Public Health Institute.

(ii) 29 District Training Teams.

However, they are not able to cope up with the training work load. In addition, they do not have facilities of clinical work treatment facilities which make their training only theoretical. Therefore, during the last 4 to 5 years, we have taken steps to develop hospitals as effective training centres especially in clinical subjects and technical procedure in addition to the regular training courses for the nurses. Progress of training during the year upto March 1987 is as follows :

S. No.	Name of the Training Programme	No. of Inst.	Duration	Capacity	Total No. trained
1.	Clinical training	33	12 weeks	110	2338
2.	IUD Training/Re-training for Female para-medicals	48	5 days	1032	8514
3.	Integrated training	28	4 weeks	131	17371

(4) **Primary Health Care in Urban Areas :**

Maharashtra State has got the largest urban population of about 36% and it may soon reach 50%. The Civil Surgeon incharge of the District Hospital has been made responsible for the implementation of the National Health Programmes including Primary Health Care in urban areas. Now Health posts alongwith the staff are being sanctioned and with their help definitely Primary Health Care in urban areas will be intensified. At present, the Civil Surgeon with his staff visits these areas frequently, organises camps, gives guidance and regularly conducts their monthly meetings to review the implementation of the National Health Programmes. For implementing this scheme effectively, Maharashtra is perhaps the first State to sanction a Class I post of District Health Officer under the designation of Resident Medical Officer (Out-reach) for every hospital.

(5) **Hospitals as effective centres for Health Education :**

Hospitals are visited not only by patients, but their relatives and well wishers, etc. It is estimated that about 5 million people i.e. 7-8% population of the State visit the hospitals in a year. Therefore, if properly developed, hospitals can act as very effective centres for mass Health Education programmes. Following steps have been taken in our State :

i. Screening of films is regularly done in all OPDs.
ii. Opel vision sets have been installed in five hospitals.
iii. Public address equipment is used in hospitals to give health messages and instructions.
iv. Health Education Stalls have been established in O.P.D.
v. Various health massages are displayed by using modern methods e.g. Glow signs/ Neon signs, etc.
vi. It is also proposed to supply one VCR to every hospital.
vii. Having one permanent Health Education Hall in every hospital school/college students can visit.
viii To have minimum 5 permanent Hoardings in the premises of every hospital for Health Messages.

This year, amount of Rs. 15 lakhs has been provided for developing permanent mobile exhibition sets for the hospitals and orders for 29 such sets have already been placed. Laminated posters for this exhibition sets will cover various topics like blood donation, Oral Health, Cancer Control, Anti - Tobacco messages, STD, Mental Health, Drug Addiction, etc. which uptill now have never been in the Health Education campaign. Similarly, flip Books for Multipurpose Workers on Blindness Control/ Tuberculosis Control, etc. developed.

In fact using hospitals as nodal itstitutions for each district, ours is perhaps the first State which has taken a massive Health Education campaign against Tobacco consumption in general and smoking in particular. As per Government Resolution, dated 5-8-1987, smoking and spitting in all the hospitals and its premises has been banned. Even pan bidi shops from the premises have been removed and ash trays have been thrown away. At a distance of every 10 meters, boards displaying Ban on Smoking under the Police Act 116 and 117 have been displayed. Hospitals have also distributed those boards to other important offices at district places and also to various health and other institutions, in the rural areas Again it will be for the first time that the hospitals will take work of writing wall slogans for which they have been supplied Aluminium Stencils on 25 important health messages. These health messages do not relate the programmes of Family Welfare/MCH/ Blindness Control as these programmes have separate machinery for Health Education.

Celebration of various News Health Days by hospitals :

The district Hospitals in the State organise following Health Day functions every year :

1.	Anti-tobacco Day	1st January
2.	Oral Health Day	5th February
3.	Drishti Dan Day	10th June
4.	AIDS Day	1st December

(6) To implement the National Health Programmes in the entire district for which the responsibility is entrusted to them :

Ours is perhaps the first State which has entrusted the implementation of following programmes in the entire district to the District Hospitals :

i. Cancer Control,
ii. Oral Health,
iii. Mental Health,
iv. S.T.D.
v. AIDS.
vi. Drug De-Addiction,
vii. Blood Transfusion Services
viii. Control of Prenatal Sex Determination and subsequent foeticide.
ix. M.T.P.
x. Disaster Management.
xi. Anti-tobacco campaign,

For the above programme, the Civil Surgeons have been declared as District Programme Officers. Though the National Health Programmes for some of the above activities have not yet been finalised, the State had appointed various Working groups which have finalised the State strategies for the same and implementation has already started, e. g. Oral Health.

(7) Conduct Training in Health for the Community :

In addition to the Health Education facilities for the patients and their relatives who attend the hospitals, it has been decided that hospitals should take further responsibility of training the community. Community not only include public at large but also vast number of gene al practitioners, traditional medical practitioners, etc. who also have to play important role in delivery of Primary Health Care. Such community training courses have been planned and are being implemented for following programmes :

i. Tuberculosis Control,
ii. STD/AIDS Control,
iii. Oral Health,
iv. Cancer Control,
v. Mental Health,
vi. Drug De-addiction

It is also proposed to start, wherever possible, training in Yoga for the public at District Hospitals.

(8) To undertake Epidemiological Surveys, Operational Research Projects, etc. in the community :

We have already carried out following activities :

i. Oral Health Survey : During June-September 1987, the Dental Surgeons attached to District Hospitals carried out a State-wide Oral Health Survery in the format devised by the Working Group for 24,000 rural population and 7000 urban population selected randomly. The data collected is being fed to the Computer for analysis. This will give a very good in-sight for Oral Health profile of the State.

ii. An Operational Research Project for integration of Mental Health with General Health Services is now being conducted by the four Mental Hospitals in the State in one Rural Hospital area of Thane/Pune/Nagpur and Ratnagiri districts. The project in Nagpur district will be later on extended to the entire district.

iii. Two pilot projects for caries control programme are being taken by the District Hospitals of Nasik and Dhule to find out the utility of fluride application.

iv. A model for developing a referral system from village level to the Apex Institution is being tried by the District Hospital, Ahmednagar.

CONCLUSION

Hospitals now cannot remain isolated from the Primary Health Care Delivery system by restricting itself within the four walls to render only curative services. They have very important and supportive role to play in enabling the Rural Health Infrastructure to deliver the Primary Health Care. Thrust should be on extension of services rather than on concentrating them in the institution. They have also to share the responsibility of training huge man power engaged in delivery of Primary Health Care and also in educating community not only to accept the services, but also to actively participate in the programme.

Facts to be Considered in the Planning of Oral Health Services

BY
DR. CLARA M. MISRACHI*

INTRODUCTION

High prevalence or serious consequences as influences in the quality of life, suffering, disability or death, make a disease to be considered as an important public health problem. Furthermore, the amount of manpower financial resources the problem absorps, in terms of cost of care and in loss of working hours, should also be included[1].

Despite the high prevalence and consequences of the two main oral health problems, dental caries and periodontal disease, are not perceived as important by the individuals or the communities because they are common and very seldom life threatening. Moreover, it is frequent in some societies to consider dental health status as an hereditary condition and the fatalistic belief that teeth will last at most up to the fifth decade of life, is predominant among them.

Dental diseases and its consequences considered universally as problems that have to be endured all life. Thus, there is a discrepancy between the oral health care needs and the oral health care demands of the communities. This discrepancy will certainly influence negatively on the political decision makers and will make decrease their interest in improving oral health services.

Although there is sufficient scientific evidence that most prevalent oral diseases are preventable, the major part of the resources available for oral health services are oriented towards curative measures rather than prevention. Moreover, the constantly increasing provision of highly technological treatment services, delivered in a dentist centered approach, has proven to be ineffective in solving the oral health problems.

However, in the past 15 to 20 years a number of industrialized countries have invested a great deal of resources in preventive programs aimed at controlling dental caries incidence.

WHO data bank (1984) confirms two major trends in oral health status: deterioration for most of the developing countries, specially in urban areas, and improvement for most of the high industrialized countries.

In the developing countries dental caries prevalence continues to increase and periodontal disease prevalence remains high. In the industrialized countries reduction in dental

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caries prevalence have occured, while the prevalence of peridontal disease may be falling to moderate[2], [3]. Although this trend cannot be substantied fully on the basis of the available data, we can assume that there will be an increase in periodontal treatment needs due to the increased dental caries control that will preserve more teeth into higher age groups, leading to more risk to this disease[4].

Considering that the oral health problems are far from being solved, even in the high industrialized countries. the lack of manpower and economical resources in the developing countries and the economical crisis affecting also the developed world, the need of reconsidering the orientation of oral health services becomes apparent.

PLANNING COST - EFFECTIVE ORAL HEALTH SERVICES.

Some of the facts that have to be considered primarily in the planning of cost-effective oral health services are :

1. Focus should be placed in applying preventive measures rather than curative ones.
2. Oral health education should be included as an essential component of every preventive measure and be based on the values, attitudes and behaviours of the invividuals and the communities regarding oral health.
3. Efforts should be oriented towards providing services on a systematic basis to priority groups rather than to isolated patients on "demand for service" basis.
4. Emphasis should be placed in the utilization of appropriate technologies in service delivery, rather than in costly high technological ones.
5. Strategies to enhance community participation in planning, implementing and controlling programs should be applied, rather than the traditional model of policy-makers and health professionals taking over all the decisions.
6. Health personal training programs should be carried out in order to provide a comprehensive multi-professional approach to service delivery, rather than the dentist centered one.

1. Preventive measures

Oral diseases prevention should focus primarily on caries and periodontal disease.

a) Caries Prevention Measures :

Since fluorides have largely demonstrated to be the best protection against caries its use should become essential in caries prevention programs.

Fluoridation of the potable water supplies should be a priority in areas without natural fluorides in the water. Although the initial economical investment is high, the benefits are considerable : 50 to 60 percent of tooth decay reduction among children

who have ingested it from birth. Efforts should be made to convince political decision makers of the benefits of this measure.

Alternative methods to provide systemic benefits to teeth are fluoridated table salt, fluoridated milk, fluoridation of school water supplies and dietary fluorides (tablets) provided in the schools. This last method is expensive for low resources communities.

Flouridated dentifrices used permanently reduce caries incidence in 20 to 50 percent. Because of the cost, this measure is not recommendable for school based programs when they are usually used at home. In communities with low to moderate resources it is better to provide flouride in mouthrinsing solutions. These, applied daily or weekly reduce dental caries incidence by about 20 to 60 per cent. Fluoride mouthrinsing has some limitations because its use depends on the availability of potable water.

Since fluorides are less effective in occlusal surfaces and caries on these represent 50 percent of tooth decay in school children, adhesive sealants occlusal applications should be combined with the use of flourides [5]. Adhesive sealants reduce occlusal caries incidence by about 40 to 90 per cent. Although its applications must be performed by trained personnel, this measure should be considered of high priority, specially in non flouridated areas.

(b) **Periodontal Disease Preventive Measures.**

Prevalence of this disease begins to be significant in 15 years old groups, being high in adults. It is mainly preventable by selfcare in terms of improved oral hygiene behaviour.

Periodontal disease prevention programs should be based on systematic education, beginning in school years and reinforced through health education programs in the communities, supervision of oral health hygiene routines and removal of calculus. These procedures can be carried out by trained auxiliary personnel. [6].

2. Oral Health Education.

Education and prevention are considerably overlaped, there can be little effective prevention without education [4], therefore each preventive measure should include an educational component to maintain interest, understanding and participation.

The main objective of oral health education is to increase the percentage of people improving their oral hygiene and other preventive behaviours such as the use of fluorides, and the increase in the rational use of oral health services [6,7].

Oral Health programs should be based on data about the values, beliefs attitudes and behaviours existing among the target-populations. This information must be available before planning the education programs. If not considered, the program will most pro-

bably fail to achieve its objectives because there will be a barrier between the scientific based message sent and the individuals values, beliefs and attitudes.

W.H.O. recomends that education should be provided to different target groups such as policy makers, the food manufacturing industry, parents, school personnel, primary health care workers, program participants, and school students [2].

Most of the oral health education activities that are being carried out, specially in the schools, are traditional in contents and in methods and are not incorporated into general health education programs. Information is provided to the target groups without enhancing their active particiption. Insufficient attention has been given to informal health education by family members, peergroups or significant adults. [8].

It is difficult that children acquire and maintain appropriate oral hygiene behaviours without their parents reinforcement at home. Therefore, parent's and children's education programs should be carried out simultaneously. It is highly recommendable to include the parents in some of the children educational activities and to train them to collaborate in the prevention programs i.e. in fluoride mouthrinsing programs. Also, they should be trained to perform self-examination of their mouths as well as to control their children's oral health at home. Parents can become the best health workers, their participation in education, prevention and control activities will contribute to lower the costs of the programs.

3. Systematic Services for Priority Groups.

Priority groups should be carefully defined after analyzing the magnitude of the oral health problems in different age groups, the possibility of success in maintaining teeth in place for a longer period of time, and the economical and manpower resources available.

Generally systematic curative services have primary school children as priority groups. Depending on the resources available the services can be aimed at conserving only the permanent teeth or to conserve the temporary as well. These services have frequently first grade primary school children as target groups and provide systematic care by controlling them through the primary school years [6]. These services should be linked with the education and preventive programs carried out in the schools. Systematic dental health care with emphasis on prevention should initially be targeted towards children, aiming at controlling caries and in the hope to reduce the long term needs for treatment of periodontal disease. [9].

When resources are available, regular services for adults should be provided primarily for periodontal disease high risk groups. [10].

4. Use of Appropriate Technologies

The use of high cost equipment and instruments and the performance by a highly

trained professional of sophisticated techniques is usually associated with high quality oral health services.

Some creative exprieences carried out in Latin America [11] show that it is possible to manufacture simplified low-cost equipment and deliver high quality, low-cost high-coverage services using auxiliary personnel and standarized instruments and procedures.

Even in developed countries equipment supplied for the curative services should be adapted ergonomicaly to the work performed. An ergonomicaly sound style of working including 'four handed dentistry' is more and more frequently adopted in the developed countries [12].

Each country, region, area or community should develop their own appropriate technologies and dentists and auxiliary personnel should be trained to use them.

5. Strategies to Enhance commnnity Participation

The implementation of strategies to enhance participation is not an easy task, specially in low socio-economical communities of developing countries where awarness of oral health problems is almost not existing.

Community leaders should be involved in defining problems and in implementing solution

Public decision makers should be fully informed about comparative benefits and cost of oral health programs before making policy decisions [13].

Suggested strategies for community participation are : [14]

- forming groups of representatives from agencies, civic organizations, trade unions, the womens movements, to examine oral health problems in the community;
- helping consumer groups conduct surveys to identify public perceptions of oral health problems and preferred methods of resolving them;
- Seminars and workshops to bring oral health problems to the attention of community leaders.

Another important strategy to consider is the involvement of mass media in providing accurate information about oral health problems and preventive methods.

6. Personnel Training Programs

The use of auxiliary personnel to perform education, and some preventive activities is accepted almost everywhere by the dental profession. The problem arises when some clinical actions are to be performed. The limits to delegation of the dentist's proper functions to an auxiliary will be different for each country and has to be agreed with the dental profession [12].

Other professionals should be trained for oral health selfcare as well as to perform

pecific actions i.e. teachers to carry out education and prevention activities in the chools. Nurses, physicians and other health personnel to detect common oral diseases eferral of the patients, and to recommend preventive measures. These actions will ontribute to oral disease prevention by means of a comprehensive multiprofessional pproach.

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DISCUSSION

Mr. Miles C. Hardie, the Chairperson summarised the three papers presented at thi Session and added his own experience of patchwork in London. The discussions focussed on peri-natal care, training of community health workers, district training teams, the role of auxiliary nurse midwife in IUD insertions and the training of traditional birth attendant. Dr. Mohamad Shafi Boikhan from Karachi (Pakistan) related his own pro blems in PHC-Responding to remarks of Dr. Boikhan, one of the Speakers, Dr Bhadkamkar narrated his share of problems in Maharashtra (India) and brought concept of public health in curative services. Dr. Bhadkamkar informed that we must hav patience rather than complaining. Dr. Jon Rohde while summing up the comments o impacts of interventions like immnnisation, oral rehydration, child spacking informe that impact of a given programme is different in different countries but reasonabl deductions can be made by study of records. The other participants who took par in the discussion were Dr. T. G. Ramamoorthy from Coimbatore and Mrs. Pramil Ghei from New Delhi and Dr. David Horner from USA. Mr. Miles Hardie thanke the Speakers for giving an excellent presentation. He also drew attention to his role i drawing up New Delhi Delclaration on Hospital and PHC 1985.

21-8-88

Video Film Presentation

CHAIRPERSON

Dr. P.N. Ghei
Secretary General,
Indian Hospital Association,
New Delhi (India)

PRESENTATORS

(1) Managing Health Centres—
A Video Film on the Management of
Primary Health Centres.

Mr. Oommen Philip
Assistant Professor and Coordinator,
Resource Group for Health Care Management.
Institute of Management in Government,
Trivandrum (Kerala) India

(2) Forty Years of National Health Services
(N.H.S.)

Mrs. J. Cumberlege
Chairman,
National Association of Health Authorities,
England and former Chairman,
Brighton Health Authorities,
London.

Managing Primary Health Centres

A Video Film on the Management of Primary Health Centres

BY
MR. OOMAN PHILIP*

The importance of Audio-Visual tools in training manpower for health care need not be over-emphasised. Audio-Visual tools help us to clarify issues and problems involved in the delivery of health care. Many issues and problems which require long time and great effort to communicate orally can be communicated to the trainees within the shortest possible time and with the greatest possible clarity and accuracy. Trainees usually react more meaningfully and sharply to incidents which are depicted in the film which can lead to greater attitudinal change and the acquiring of deeper knowledge and sharpening of tools.

It is with the above perspective that the Institute of Management in Government took to developing audio-visual tools for training in health care in the Kerala setting. The video-film, "Managing Primary Health Centres" was visualised through the eyes of a prospective or current manager of a Primary Health Centre in trying to find meaningful answers to the grave problem that PHCs are faced with in their effort to achieving Primary Health Care. The case studies and the field studies that the Institute has taken up have proved beyond a shadow of a doubt that attitudinal issues and leadership styles play the most vital part in the managers and prospective managers of PHCs wanting to use modern management techniques in properly and efficiently managing the PHCs.

This film had the management of Primary Health Centres focus attention on various aspects of planning, co-ordinating, directing, controlling and motivating the various resources of a Primary Health Centre, and goes on to high-light the strengths and weaknesses of the prevailing management practices in them. Leadership is stressed as being the most important of these requirement in managing a Primary Health Centre. A contrast is made among the styles of 3 medical officers, (1) an extremely active, another an extremely indifferent and the third, a dedicated and quiet medical officer. A Junior Public Health Nurse, a Pharmacist, a Laboratary Technician, a few groups of office staff and some nurses in the wards of the main centres have all been introduced in their work situation. A situation analysis of two PHCs with their strengths and weaknesses is clearly depicted in the film. A subcentre is also in the vogue. The visuals and narrations

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clearly bring to lime-light the various problems and approaches in the main centres of the PHCs and their peripheral units. An effort is also made to bring about the various dimensions of the image of the Primary Health Centres.

The film provides the viewers with several provocative and sensitive incidents, expecting them to react to these with a view to help to solve similar problems in their own PHCs. Another feature of the film is that it brings forth the basic principles of management through narration, visuals and actions.

This is a film with a strong message to all Health Administrators (District Medical Officers, Medical Officers of Primary Health Centres, students and Professors of Community Medicine etc.). It is also a useful tool for trainers in health care in the Medical Colleges, Institutes of Management and Institutes of Health Management Training. The film has a setting suitable for Third World Countries and so it can be of use for the training of Health Administrators of the Third World Countries conducted anywhere.

This film was produced by the Resource Group For Health Care Management, Institute of Management in Government, Trivandrum, with financial assistance from the Training Division, Ministry of Personnel and Training, Government of India. Its duration is 25 minutes. It is in VHS and in beautiful colour. The language used is English. The original script was written by Mr. Oommen Philip, Co-ordinator of the Resource Group For Health Care Management, who was also the Executive Producer of the film.

The write-up on the film shown by Mrs. J. Cumberlege may be had, for those interested, directly from her. An interesting discussion on the Film followed. The consensus summarized by Chairperson that we should make increasing use of our various media aids for education of community on subjects like PHC & Child survival intervention like growth monitoring, oral rehydration, breast feeding, immunisation, etc., particularly for target community among urban lums and rural poor.

22-8-88

Dr. B. L. Kapur Oration

CHAIRPERSON

Dr. P. N. Ghei
Secretary General
Indian Hospital Association
New Delhi (India)

ORATOR

New Models for Health Management Education—A World Perspective
Mr. Robert A DeVries
Programme Director
W. K. Kellogg Foundation
400, North Avenue/Battle Creek
Michigan (USA)

TO CONFER HONORARY MEMBERSHIP OF INDIAN HOSPITAL ASSOCIATION

RECIPIENTS

(1) Dr. Roy J. Gerard,
(Director, KIFPH
Michigan State University
College of Human Medicine
East Lansing
Michigan (USA)

(2) Mr. Miles C. Hardie
Member, Steering Committee and
Former Ditector General
International Hospital Federation
London (UK)

VOTE OF THANKS

Dr. M. S. Nanda,
President
Indian Hospital Association
New Delhi (India)

Dr. B.L. Kapur Oration

BY

ROBERT A. DeVRIES

This Oration is held every year since 1971 in the memory of late Dr. B. L. Kapur who was the Founder Secretary of Indian Hospital Association. The Oration this year is on the subject of 'New Models for Health Management Education—A 'World Perspective'' delivered by Mr. Robert A. DeVries, Programme Director, W. K. Kellogg Foundation, Michigan (U.S.A.).

Mr. Robert A. DeVries is Program Director, W. K. Kellogg Foundation, Battle Creek, Michigan U.S.A. Before taking this post 17 years ago, he served as Chief Executive Officer of a community hospital and health center in Michigan. He holds a BS (Physiology) Degree and MBA (Hospital Administration) Degree from the University of Chicago. He is a Fellow of the National Center for Health Services Research, the American College of Healthcare Executives, and the Canadian School of Management. Author of numerous articles, He is an Honora y Lifetime Member of the American Hospital Association and Honorary Advisor to Beijing Medical University, Medical College for Health Staff, Shanghai, and the Shanghai Number One People's Hospital. He lectures at the University of Michigan and this July was appointed Advisor on rural health to the United States Secretary of Health and Human Services.

(Dr. P. N.Ghei)

Distingiushed colleagues, Ladies and Gentlemen: I am very honored to give the 1983 B. L. Kapur Oration on the topic of New Models for Health Management Education : Vorld Perspective. And I am delighted to be in this ancient city, a cultural and itical center for India. As many of you know, Dr. Kapur was the founding secretary he Indian Hospital Association and one of India's leading health figures. As the nteenth presenter in an unbroken line dating to 1971 and as the first United States zen to present this memorial address, I feel a deep sense of responsibility. I hope to

convey my dedication to health care and my passion about this young and growi profession—health services administration—a profession that is so vital to the prop *organization* and *delivery* of quality health care. I am grateful to those of you whon know—old friends—who have traveled here to join us at this international workshop hospital and primary health care, and I look forward to meeting many new colleagues.

For four reasons health management education is a timely and important topic our consideration. In every part of the world, from Buenos Aires to Boston, fr Beijing to Barcelona, heavy demands for improved performance and productivity placed on health administrators. Regardless of the region of the world, whether yo country is a developing or industrialized nation, it has faced new demands for co effectiveness, improved access and quality of care, and advances in new and very expens medical technology. Whether you live in China or Chile, the speed of change a reorganization in health care delivery has been breath taking during the decade of the 80

Health care is big business and it consumes a big portion of government's budg Whether you are a citizen of Singapore, Shanghai, London, or Lisbon, governmer business, and worker's organizations alike insist on new ways to contain and control spiraling costs of hospital and medical services. These rapid environmental changes societal pressures are one reason why renewed attention should now focus on the m appropriate ways to prepare tomorrow's health services executives and medical admi trators.

A second reason why health management education is a timely and important to is that during *this decade* four world region associations have dedicated themselves to advancement of health administration education. The oldest of these—the Association University Programs in Health Administration, Washington, D.C.—was founded in mid 1940's. It serves the U.S. and Canada. In 1979, the secretariat of the Europ Healthcare Management Association, Dublin, was established. It now has more than member programs in more than 20 countries More recently, the PROADSA, the c sortium of 10 leading Central and South American programs based in Sao Paulo SHAPE, Secretariat for Health Administration Programs in Education for Australa Adelaide, began operations. Now, through well planned educational and informatic efforts by these four world region associations, we have recognized, productive vehi for strengthening the education of tomorrow's health administrators.

Yet a third reason for the timeliness of this popic is that just this last May at Ox University, through support from the W. K. Kellogg Foundation, two dozen internati leaders in this field met to share approaches for revising curricula, introducing teaching methods and educational materials, and comparing their rich experiences in preparation of health service managers and health policy leaders. A meeting such as one at Oxford, clearly illustrates international cooperation on this important issu does our own meeting here in New Delhi.

Finally, there is also the feeling that the health care field internationally, is looked to by leaders of other human service fields such as education, public administration, and social services, as a change agent and modeler of things to come. Perhaps there is truth in this view since the provision of health services is such an important part of every government's budget, since health care delivery enjoys unusual dynamics in both the public and private sectors, and since many health professionals are influential in the shaping of higher education and government policies.

As a backdrop for the five new models for health management education that will close this paper, I'll mention six main issues that most countries, third world and industrialized, confront in preparing tomorrow's health executives. I am grateful to colleagues who assembled with me at Oxford University this May for their identification of these international issues in health services administration education. I believe that if we are to make real headway in the WHO "Health for all By the Year 2000" challenge we must advance the competence and capacity of tomorrow's health services management at all levels -- primary, secondary and tertiary; in hospitals, longterm care facilities; and ambulatory services. WHO Geneva recognizes this point and is giving renewed attention to strengthening the preparation of tomorrows' administrators.

The first of six issues is to set **priorities** for these educational program. Which of these program responsibilities should come first — teaching, research and publishing or community service and consulting ? For many, the easy answer is teaching; the main job of the educational program is to prepare tomorrow's administrators. Yet, several of the leading programs in health administration in Europe, China, and Mexico assign high priorities to community services and consulting. And several of the leading programs such as the University of Michigan with the Health Administration Press and Leuven University, Belgium, with the European Health Policy Forum, have contributed much to the literature in medical economics, medical care organization, quantification, and medical sociology. Obviously, there is no clear answer to the priorities question, but by raising it, programs are challenged to examine their most appropriate role and contribution, for their country and environment.

The second issue poses the question of what shall be the *balance* in the educational program between the clinical, public health and medical care organization dimensions, versus the management, business, and quantification dimensions of the program? Globally, some educational programs remain directed and dominated by a 1940 view of public health; some are medical school captives and the training is heavily oriented to the academic or private practice of medicine; some programs are fully embraced while others are barely tolerated by their parent schools of public health, public administration, engineering, or architecture. For most of the industrialized nations, formal education in health administration has been in place for more than 20 years. The orientation of these pro-

gram's has moved from the traditional public health model to management and business; it has moved from granting diplomas to awarding masters degrees; and it has moved from a focus on institutional and functional aspects to become issues oriented. Along with these movements many of the better programs have reduced their degree-granting or majors in nursing home administration, ambulatory care administration, hospital administration, and hospice administration favoring a more general liberal education that stresses problem solving, measurements, and assures a *balance* between medical care organization and general management.

The third issue : How best might health administration education programs be *recognized and sustained* in their larger, internally competitive parent organizations, all of which face resource restrictions or reversals ? As it turns out, the politics of program growth and development are critical to the survival of these relatively small educational units. Health administration faculty are but a fraction of the huge faculties of medicine, pharmacy, dentistry, and nursing. Here you have a mouse waltzing with four elephants! Its easy to be stepped on or smothered. Part of the answer to this issue lies in the selection of a sympathetic "mother" school. From what I have observed, *opportunism* university *structure*, and the *environment or country culture* are the most important factors in identifying the best locus for the program. Clearly there is not a single answer that is right for all. And one keeps in mind that the best programs nurture an integrated faculty from management, mathematics, measurements, medicine, public health, political science, economics, sociology, and public administration.

The fourth issue: How can universities, professional associations, and ministries best *prepare clinicians* for administrative posts ? In the United States and Canada there is a movement toward increasing the numbers and types of physicians, dentists, and nurses in health administration. Of course, for most countries, especially third world nations, the vast majority of senior health administrators were first qualified as clinicians before becoming administrators. Good evidence exists that both clinicians prepared in management and nonclinicians with baccalaureate and masters degrees in health services administration are needed in increasing numbers, worldwide.

As for physicians in management, they are needed at many different managerial levels—for medical units within a medical center, to head up multi-disciplinary clinical divisions, to serve as chief executive officers of medical institutions and health systems and in key provincial and central government posts. As we entered the decade of the 80s, scarcely several handsful of physicians were enrolled in formal degree programs in health administration in the United States. Happily, in recent years leading medical schools and academic health centres have recognized the value and legitimacy of formal preparation in health administration for interested clinicians. Through nontraditional and

adult learning technology, hundreds of physicians are becoming credentialed in health management.

As for professional nursing, there exists in almost every country, an extraordinary demand for competent nurse executives. I don't know why it should be but nurse leaders, senior physicians, health service board members, chief executive officers of hospitals, ministry officials, and university presidents alike, point out the huge deficit in well-prepared nurse management. Perhaps the management and administrative functions are seen as crosscurrents to the traditional attitudes and values of nursing practice. Perhaps the demands of office for the nurse executive discourage recruits; perhaps the schools of nursing themselves question the value and discourage their graduates from a career in nursing administration. In any case, I see this huge international deficit as a roadblock toward the *vertical* integration of levels of care and the achievement of Health for All by the Year 2,000.

Fifth issue : To what extent should educational programs in health administration be surveyed, accredited, reviewed, and monitored for the *quality* of the educational experience ? What is the appropriate balance between external survey and internal audit for quality instruction ? In some parts of the world educational programs may apply for voluntary accreditation survey. Within this formal accreditation process, and based on published standards and practices, an external team of colleagues on behalf of a national accrediting authority makes an on-site survey of the program and documents its strengths and shortcomings. These lead to essentially a pass/fail position or full, partial or non-accreditation.

In other parts of the world, Europe for example, a program review process is available. Under this system, programs are reviewed on site by a visiting team of colleagues who consult on the strengths and shortcomings of the program and *assist its development*. In this review process there is no pass/fail or statement of accreditation. Both systems offer distinctive strengths and emphases for the timely monitoring of quality instruction and both systems raise the need for a common international, semantic glossary to clarify their common and contrasting dimensions.

The final issue : Where will tomorrow's *teachers* in health management education come from ? Will they have been master practitioners anxious to impart advice, values, and "how to do it stories" to students ? Or will they be drawn from the basic disciplines, such as economics sociology, biostatistics and the like ? Will the better programs insist on a combination—a blend of scholars from the disciplines and the world of practice ? As I have watched some of the better programs develop in Europe, South America, Australia, and the United States it is clear that the movement is toward encouraging scholars from the basic disciplines to commit to research projects, teaching, and consultation in health care management and governance. A number of the better programs

encourage master practitioners to serve as scholars in residence, preceptor graduates, and offer field experiences but they do not constitute the core faculty. It is clear that the backbone of these programs is made up of scholars from the disciplines who seem to be in the best position to research question, project issues, and teach about subjects that tomorrow's practitioners must know.

The closing part of my paper will feature five, contrasting new important educational models in health management from four countries; Brazil, Canada, China, and the United States. As I see it, each of these programs is making a unique contribution, both in its region of the world, and internationally, for the advancement of health management education.

As one of the first two graduate programs in health and hospital management in South America, the University of Sao Paulo School of Public Health in 1951 began a classic, formal, preservice masters degree program that has now graduated many distinguished health executives and statesmen for Brazil—the largest country in South America. With a rich heritage and ideal location, this program served with distinction for many years. However, its heavy orientation to classic public health, its traditional approaches to instruction, and new substantial demands for management and business courses in the curriculum have recently led to a dramatic and responsible change in both the program's orientation and delivery. Following a year of reorganization, this program reopened last year with new attention to management, economic, and environmental focuses. The traditional Monday through Friday 8:00 a.m. to 4:00 p.m. courses were replaced by afternoon and evening instruction, thus appealing to practicing administrators who were seeking a credential. Here is an example of a well established, highly honored, visible traditional program that underwent major reorganization and reorientation to fit its student market. The changes were radical but timely and the program is now moving into a new era of service to the Brazilian people.

Practically next door to this School of Public Health is another masters program started in 1976 in one of Brazil's most distinguished schools of business of the Getulio Vargas Foundation. In addition to its choice location, the program is a true partnership between the Getulio Vargas academic institution and the Hospital das Clinicas, one of South America's most sophisticated medical centers and has brought benefits to both institutions. While the program was originally oriented to the management of complex medical centers, its focus has shifted to the management of the total health system. Now it plays a major role in preparing managers for the Brazilian health sector reform. The Getulio Vargas Master's program offers the graduate degree as well as a certificate leading to a specialization, a medical residency program linked into management training, undergraduate teaching in business administration, and continuing professional education in this field. Applied research is also a major component, especially in systems analysis and

operations research. Clearly, the Getulio Vargas program has been one of the most active of te Latin American programs in the publication of books and monographs.

In the Country of Canada thirty-eight years ago, and under the aegis of the Canadian Hospital Association a series of correspondence courses and informal instruction became available for non-credentialed administrators and mangers of smaller hospitals and non-hospital agencies, nationally. This program, Health Services Management, has experienced substantial growth, remarkable progress, and national credibility. Today it includes university accredited courses that may be taken at a number of colleges and universities across Canada and it adds to that a set of carefully constructed core courses which together allow the candidate with further study to complete the baccalaureate or even the masters degree. To date, there have been more than 2, 800 graduates from the Canadian HSM national program. Its contribution to the elevation of management, especially for the rural communities in Canada, is one of the greatest national achievements in quality instruction in this field. HSM serves as a model for other nations regarding how one can effectively package quality education and make it readily available. Today, HSM is a knowledge base for professional recognition by the Canadian College of Health Service Executives.

Moving to the People's Republic of China, remarkable strides have been taken since 1983 by a half dozen universities recognized by the Ministry of Public Health. For example, Beijing Medical University in the capital city has effectively put in place three levels of education for health management—baccalaureate, masters, and a post - graduate program for senior administrators, teachers and researchers. These are taught under the university's school of public health and are seen as national models. Similar programs are also developing in Shanghai, Harbin, Xian, Wuhan, and Chengdu. Until 1983, this vast country with more than a billion people, had no method formally credentialing health care executives. Now through a careful step-by-step approach, China has effectively laid the ground work for quality instruction and is paying special attention to the in-service education of mid-level and senior managers already in practice. Boldly and directly, national attention has been given to the preparation of tomorrow's administrators and leaders for health care; this will surely influence the structure, decentralization, efficiency, cost, productivity, and quality of care for the Chinese people.

The final program I'll identify is a consortium known as the Western Network Executive Masters Program in Health Administration. It is based at the School of Business, University of Colorado, in the United States. It is dedicated to the credentialing of clinicians and non-clinicians who find themselves in senior administrative positions but lack the required education. Originally, five universities in the western part of the United States banded together to offer this nontraditional adult educational experience. The five school are the University of California, Los Angeles and Berkeley; University of Washington

Seattle; Arizona State University; and the University of Colorado. Forty-eight credit hours are required for the masters degree. Each course lasts six months, of which only two weeks of instruction is in residence on the Colorado campus. Heavy reliance is placed on independent learning and field experiences. Student-instructor interactive computer conferencing, designed to simulate the classroom is a critical component for delivering the courses. To date, there have been 55 graduates of this program that began only in 1985.

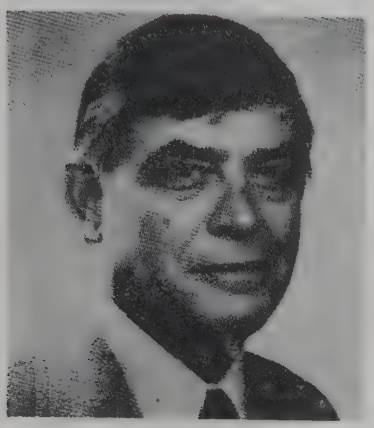
Now with an understanding of why this topic is important and an identification of six international issues--educational program priorities, carricula balance, program viability, clinician preparation, instructional quality, and faculty sources -- we have looked at five successful, contrasting educational models.

In closing, we all need to be reminded of the remarkable progress that has been made. Just think, the very first viable graduate degree program in this young, important field was established as late as 1934 at the University of Chicago. Since then, hundreds of baccalaureate and masters program have been started, embracing all of the major countries of the world and the demand for competent graduates continues unabated. Now we see special renewed attention given to the credentialing of clinicians in health management nontraditional adult educational programs starting for practicing administrators who are not credentialed, and the formalization of the profession through such organizations as the Canadian College of Health Service Excutives of Great Britain, and the American College of Health care Executives.

While great strides have been made much remains undone. In a recent lecture given at the University of Alberta, Dr. Gary Filerman, President, the Association of University Programs in Health Administration, spoke of the "organizational revolution." He said, "We are in the early stages of the **organizational** revolution in health services. In the modern era, it is the fourth revolution, following anesthesia, Flexner, and antibiotics. Each changed the practice of medicine profoundly and so too will the organizational revolution. Each was based on good science. So is the organizational revolution."

New models of instruction, new methods of delivery, and new markets for physicians and nurses in health management are begging for our attention. We are qualified to deal with these challenges. But if we fail to meet them we will surely be delaying progress in the provision of health care for the world's people. None of us want that to happen. Working together we can continue the progress that is underway.

Recipients of Honorary Membership of Indian Hospital Association, New Delhi, India



Dr. Roy J. Gerard

Mr. Miles C. Hardie

Vote of Thanks by Dr. M.S. Nanda
President, Indian Hospital Association, New Delhi

The Indian Hospital Association is indebted to Mr. Rober DeVries for accepting our request and delivering today's Oration. This Oration will remain a trend setter in this field for a long time. I am also thankful to him for having accepted a token gift in appreciation of the Oration delivered by him.

I am also thankful to Dr. Roy J. Gerard and Mr. Miles C. Hardie for accepting our requests of becoming Honorary Member of Indian Hospital Association. Both Dr. Gerard and Mr. Hardie are leaders in the respestive fields and have contributed a lot towards the achievement of 'Health For All' and better Management in Hospital. We have linked a very long association with the Indian Hospital Association by conferring Honorary Membership. The Indian Hospital Association stands gained by their still deeper support and commitment to the objectives of Indian Hospital Association.

I am grateful to International Hospital Federation, UNICEF, WHO National and International agencies and distinguished nominees who are here to take part during this Workshop. We also welcome every delegate from India and abroad who have responded to our request in such a magnificiant manner.

Many of you know that this International Workshop is a follow up of 1985 international activity where after the Conference we adopted a 'New Delhi Declaration' on Hospital and Primary Health Care. I do hope that distinguished delegates will have time to discuss and recommend a suitable 'Declaration' by the end of this three days Workshop.

22.8.1988

Scientific Session II

CHAIRPERSON

Dr. B. D. Miglani,
Vice President,
Indian Hospital Association,
New Delhi (India)

SPEAKERS

(1) Hospital and Primary Health Care (PHC)
Dr. (Mrs) Tripta Bhasin,
Ministry of Health and Family Welfare,
(Department of Family Welfare),
Government of India,
New Delhi (India)

(2) Role of Fr. Muller's Cheritable Institutions in (PHC) through Rural Community Development Programmes
Lt. Col. (Miss) C. Thyagrajan (Retd.),
Principal
Fr. Muller's College of Nursing
Fr. Muller's Charitable Institutions
Kankanady, Post Box No. 501,
Mangalore (South India)

(3) Total Health Care (THC)—Tata Tea Model
Sq. Ldr. V. Suresh
Tata Tea Limited
Medical Department,
Munnar, Kerala, India.

Hospital and Primary Health Care*

BY
DR. MRS. T. BHASIN**

Health Care Delivery System varies from country to country as it depends on the levels of socio-economic development and development of health services in that place. The hospitals plays an important role in the delivery of health care and in fact in the earlier times they were synonymous with the health care delivery system.

Definition of Hospital

In the first report of the WHO Expert Committee on 'Organisation of Medical Care', the hospital was defined as an integral part of a social and medical organisation, the function of which is to provide for the population complete health care, both curative and preventive and whose outpatient services reach to the family in its home environment. The hospital is also a centre for training of Health Workers and social research.

However, it is an acknowledged fact that hospitals have been playing an important role in providing health services to the people especially during earlier days when most of the services were curative in nature. In the earlier days hospitals were made to provide relief to the patients who were unable to take care for themselves. Special hospitals were earmarked for treatment of infectious diseases and mental illness in which the patients were isolated as this was considered the only method to protect the remaining population. The relative isolation of hospitals from the broader health programmes of the community had its root in the development of health services which had contributed to the dominance of disease model. The orientation of most physicians to the individual patients and the tendency of all health related organisations to expand in specialised field led to form hospitals as ivory tower of disease. Hospitals are not the place to die as were earlier thought but are the place for the diagnosis and management of patients with serious or complicate disease which is beyond the scope of care at the primary health level.

In most countries the hospitals are recognised essentially as an establishment intended for treatment of disease or injury arising in the community. It ensures that persons suffering from de-generative disease and incapicitated by senility find shelter and receive attention and it may also provide maternity cure.

History of Primary Health Care in India

Primary health care in India is not a new concept in the history of health services. The Health Survey and Development Committee Report (Bhore Committee 1946)

**The best Essay of Year 1988*

**Asstt. Commissioner (RHS), Ministry of Health & Family Welfare, New Delhi.

recognised the inter-sectoral efforts required to provide basic health services to the community. It laid special emphasis on certain basic essentials like suitable housing, sanitary surroundings and provision of safe drinking water. Development of health services were considered as an integral part of the socio-economic development as such among their recommendations the Committee also recommended Government's efforts towards elimination of unemployment, provision of minimum wages for all and improvement in agriculture and industrial development. It was an attempt to have an integrated all-round rural development and one primary health centre was recommended to be established in each block with the operational responsibility to provide medical care, control of communicable diseases, MCH, nutrition, health education, environmental sanitation and collection of vital statistics. This concept has been retained in the primary health centres even today.

The community development programme was launched on 2nd October, 1952 as the first Integrated Rural Development Programme with health as one of its important component. It was proposed to establish one primary health centre with 3 sub-centres, for every community development block covering a population of about 60,000. The primary health centres were conceived as an nuclei from which the primary health services would radiate through sub-centres over the countryside. These primary health centres were envisaged to cover medical care, control of communicable diseases, maternal and child health, environmental sanitation and collection of vital statistics. Each primary health centre had one doctor and each sub-centre was looked after by a trained midwife who looks after MCH services.

The subsequent Committees (Mudaliar Committee 1961) also studied the functioning of PHCs to improve their operations. It recommended reduction in the population covered by them and extension and strengthening of district hospitals. 1973 Committee on integration of health, family planning and MCH services (Kartar Singh Committee) decided to have an integrated approach for delivery of health services by progressively introducting multipurpose workers, health workers and supervisors.

In order to give priority to the rural health development services, the Government of India introduced the concept of Minimum Needs Programme during Fifth Five Year Plan (I974-79). The establishment of primary health services and sub-centres, upgradation of primary health centres and construction of buildings for PHC/sub-centres and staff quarters were included under this programme.

The primary health care approach was adopted by India in 1978 as it became a signatory to the Alma Ata Declaration. The primary health care as defined by WHO is "essential health care made universally accessible to individuals and community by means acceptable to them through their full participation at a cost that the country can afford. It should form an integral part both for the country's health system, of which it is the nucleous and of the overall social economic development of the community."

Components of the Primary Health Care

The various components which are included in primary health care are :

1. Education of people about prevailing health problems and methods of preventing and controlling them.
2. Promotion of food supply and proper nutrition.
3. Adequate supply of clean drinking water and basic sanitation.
4. Maternal and child health care and family planning.
5. Immunisation against major infectious diseases.
6. Prevention & control of locally endemic diseases.
7. Appropriate treatment of common diseases & injuries.
8. Provision of essential drugs.

The principle underlying Primary Health care are :—

1. Equitable Distribution,
2. Community Distribution.
3. Multi-sectoral approach.
4. Appropriate technology.

It is clear from the above that primary health care means much more than clinical treatment of states. In fact it refers to essential health care made accessible to everyone through their full participation and at a cost that a country can afford. This approach should be integrated at the community level of the elements necessary to make an impact on the health status of the people.

This primary health care approach was reflected in the National Health Policy which was passed in the Parliament in 1983 which recognised that the hospital based disease and cure-oriented approach towards the establishment of health services has provided benefits only to the upper crust of the society especially those residing in the urban areas. Further more the high emphasis on curative approach has led to neglect of preventive, promotive and rehabilitative aspects of the health care. National Health Programmes lays down restructuring of the health services with the following broad approach :

1. Establishment of well dispersed network of comprehensive health care services, integrally linked with extension in health education approach taking into account that large number of health functions can be performed by well trained volunteers, auxiliaries and para-medical workers.

2. Large scale transfer of knowlege, simple skills and technologies to health functionaries selected by the community and enjoying their confidence.
3. Decentralisation of the primary health care system with the active community participation having adequate support of the secondary and tertiary levels.

As a result of these developments the urban slums were left out. Hence a Committee was formulated in 1982 (Krishnan Committee) on reorganisation of family welfare and primary health care services in the urban areas. The observation was that health services in city tend to be largely cure oriented and delivered through hospital and clinics/ dispensaries. One of the broad recommendations that an integrated sub-central approach with suitable out-reach services is essential in the urban areas to provicle for promotive and preventive health care. The referral from these centres should be to the nearest hospital for clinical and specialised services.

With this background of primary health services we can define the functions of general hospital. In discussing the functions of a general hospital in the light of modern medical knowledge it is felt that a general hospital should not limit its functions to the restoration sphere alone but should in so far as circumstances permit organise itself to provide preventive, educational and research needs as well. These functions are summarised as below:

1. Restorative

(a) diagnosis: an out or in-patient services;
(b) treatment of disease: curative and palliative involving medical, surgical and special procedures;
(c) rehabilitation : physical, mental and social;
(d) care of emergencies: accidents and disease.

2. Preventive

(a) supervision af normal pregnancy and childbirth;
(b) supervision of normal growth and devclopment of child and adolescent;
(c) control of communicable diseases;
(d) prevention of prolonged illnesses;
(e) prevention of invalidism, mental and physical;
(f) health education;
(g) occupational health.

3. Educational

(a) medical undergraduates;
(b) post-graduates; specialists and general practitioners;

(c) nurses and midwives;

(d) medical social workers;

(e) other allied professions.

4. **Research**

(a) physical, psychological and social aspects of health and disease;

(b) hospital practices, technical & administrative.

In order that hospitals may be organised and equipped adequately staffed with qualified personnels to handle the conditions occurring less frequently they should be so placed as to serve reasonably large groups of population, with commonly occurring and mild diseases, can be treated in less equipped peripheral hospital. The hospitals can be grouped as below:

1. The Regional Hospitals which my be generally located in chief towns and regions and may work in collaboration with the Medical College. They can be fully equipped with highly specialised departments.
2. Intermediate hospitals which are responsible for similar districts can have number of departments including common specialists like medicine, paediatricians, surgery, obstetricians, E&T, Ophthamology and X-Ray Department.
3. The local hospitals which provide general medicine, surgery and obstetrics for day to day needs of a small localised group.

The local hospitals in the context of primary health care in India are called Community Health Centres which are having 30 beds and with specialists like medicine, surgery, obstetrics and gynaecology and paediatrics are represenred.

Radical changes will be needed in the function of hospitals if they are to become integral part of the National Health Systems based on primary health care. The functions of the block level hospitals which provided the referral care should be responsible for :

1. Supporting primary health care.
2. Promoting community health development action.
3. Basic and continuing education of all categories of health personnel; and lastly
4. Research.

Supporting Primary Health Care

In India, community health centre having 30 beds and specialist services are acting as a first point for reference. Patient needing special facilities and expertise will be referred to them by the first contact level and refer back to that same level when the state

of health permits. This referral of patient is just one aspect of primary health care which is often not working as envisaged because people having no confidence in the primary health care level go directly to the block level hospitals that is the community health centre as a result some are admitted who do not really need hospital care. The block level or the district hospital who take the role of providing guidance and advice continues giving technical backup and supervision. Continuing education and adequate follow-up of patients released from hospitals and monitoring of agreed health programmes should be one of the key duties. These hospitals should also provide managerial support to the planning and organisation of health system in the district and to the organisation of primary health care by the community.

The hospital should take up actively the role of health education in prevention of diseases. It is seen that when a person is sick he listens very carefully to the advice given to him. At the same time he should be given advice on nutrition, improved sanitation and need for cleaner water. It is felt that the proper referral system should be developed in which primary health workers have to sit down with the hospital staff and work out the type of patients who have to be referred by them. Both teams need to have a clearer idea of the categories of patient with which it will be dealing with so that patients are treated at the proper level. The referral at the first level must be developed so that there are clear guidelines for referred patient to district hospital' to the regional hospital and the regional hospital patient to referral hospital.

Promoting Community Health Development Action

The first referral hospital should play a leadership role in promoting action for community health development through the active involvement of the community for this the hospital has to come through the four walls to the community itself. Their action should aim at encouraging community decision making and control in protecting and promoting its own health in combating bad health habit and promoting in achieving adequate health services all in the spirit of self-reliance. A further new element in promoting community health development is the one exciting avenue of nature sectoral cooperation. The hospitals are for advice to the community in the field of nutrition, population, environmental or water supply will have to cooperate closely with other development sectors including agencies responsible for food production and rural health.

Basic and Continuing Education of Health Personnel

Basic and continuing education is also one of the tasks for some hospitals. Invariably hospital direct the health personnel trained by them towards curative care, using the most sophisticated and highly technological equipment leading dehumanisation of the health care. It is not surprising to find that health personnel trained in hospitals are characteristically preoccupied by curative care alone.

The hospitals will have to become more and more involved in the training of all categories of health personnel including medical students. This training can no longer be confined to the hospital but should be extended beyond the hospital. The health workers should learn how to function in teams both in the hospital and outside in the community.

They will not only learn how to anlayse community health situations and serve, support, guide and educate communities and individuals in their fight for health but will also become socially motivated to do so. By involving trainees alongwith practising health workers, in functioning health teams responsible for health development, the hospital can provide opportunities to introduce learning by experience, learning by doing, taking training out of the classroom and wards and orienting it to the needs of the community, in brief, to learn about the primary health care.

The training responsibilities of the hospital should not stop here but will have to keep on participating in the continuing education programmes. The continuing education has to change in character and should be considered for all workers concerned with health and relate to their problems. It should lead to the improvement of daily performance of health workers for preventive, promotive, curative and rehabilitative work.

Research

The block level hospitals are the apex hospitals being located physically and psychologically near communities will have to become involved in particular in the kind of research that aims at discovering the most efficient and effective ways of applying appropriate health technology, whether primary health care or by the supportive hospital system and at finding behavioural alternatives to such technology.

Hospitals have an important role in encouraging the growth of primary health care which in some areas they are already pursuing. The hospitals should be associated with a well defined catchment area within a regionalised framework. The total health care of the community of that catehment area should be delegated to them. In the teaching hospitals the departments of community health have a greater responsibily to mobilise interest, expertise and direct interaction with the clinical services and with the communities in the catchment area. The community health departments can act as :

1. Support and encouragement to primary health care programmes in the hospitals' catchment area;
2. Inservice training for reorienting hospital health workers in order to change the 'hospital outlook' to a (again not avilable matter in the slip ?).
3. Cooperate with the educators and supervisors of primary health care workers in the field to improve training management and administration:
4. Collaborate with the community seeking relevant information on health problems and appropriate solutions;

5. Ensure that the hospital meets its referral and logistic support responsibilities;
6. Develop effective ways in which the communnity can support and assist in improving hospital services;
7. Work with other sectors, non-governmental organisations and community associates including women's groups active in the catchment area;
8. Identify gaps in the delivery of primary health care services and introduce appropriate ineovations;
9. Stimulate and conduct relevant health services research which focuses on practical issues to achieve a progressive improvement of services.

Conclusions

As we are all aware the International Conference on Hospital & Primary Health Care was held from 20th to 25th January, 1985 in New Delhi, India jointly sponsored by Indian Hospital Association and International Hospital Federation, London. The purpose of the Conference was to renew and stimulate progress in the development of the role of hospitals in promoting and supporting and providing Primary Health Care. The Conference also renewed conclusion and recommendation of Karanchi Conference which was sponsored by Aga Khan Foundation and W.H.O. in 1981 on Hospital & Primary Care.

The recommendations of this International Conference (1985) were summed up in New Delhi Declaration on Hospital and Primary Health Care which are :

1. Emphasis has not be on whether hospitals have a role in Primary Health Care but on how hospitals can become fully involved in the practice of Primary Health Care.
2. In order to promote Primary Health Care, ten priorities emerged;

2.1 The formulation of a health policy centred on primary health care.
2.2 The development of the health infrastructure with special reference to referrals.
2.3 The development of sensitive indicators.
2.4 The identification of appropriate technology.
2.5 The development of health manpower.
2.6 The education and training of all categories of staff.
2.7 Community involvement.
2.8 The development of a suitable health information system.
2.9 The optimisation of financial support and the maximisation of scarce resources.
2.10 The monitor and periodic evaluation of outputs and programmes to effect corrective steps.

3. All agencies-governments, corporate, voluntary and private-must work together towards the achievement of pre-set goals and targets with clear dates.

4. Progress in the implementation of Primary Health Care should be reviewed by a suitable forum at specified intervals.

In the last Conference in one of the presentation the eight primary health care role of the hospital was beautifully presented and can be remembered as :

H stands for health services
O for operation research
S for supervisory support
P for planning
I for information support
T for training
A for augmenting referral system; and
L for logistic support.

We are not at that stage when we have to review the progress of implementation of Primary Health Care. I will just conclude by saying that it must be remembered that hospitals are part of the total health system and plays an important role in the health care delivery. It should not be thought in isolation as two separate component but as integrated part of a single system then only the health status of the people can improve and we will reach to the goal of Health For all by 2000 A.D.

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Role of Fr. Muller's Charitable Institutions in Primary Health Care through Rural Community Development Programmes

BY

LT. COL. (MISS) C. THIAGARAJAN (Retd.)

SUMMARY

The 108 years old Fr. Muller's Charitable Institution (F.M.C.I.) made a landmark in its history by launching a Centenary project - Rural Health Programme in the year 1980. The corner stonc laid in Mullerkad and Shanthinagar villages on an experimental basis has become a rocky tower-house with two great pillars to support—A moving spirit Rev. Fr. P.S. Noronha the present Director and the other invisible spirit and soul of Fr. Muller himself. Each stone represents the individual from community. The inter and intra cellular layers are plastered by the solid, scientific and safe efforts by the central team headed by a Project Officer and the field team lead by the Community itself at the grass root level. The architect is funded by number of sister organisations and well wishers. The interior decoration has been made possible by the evaluation and feedback by Indian Social Institute, New Delhi.

The two bifurcate Mangalore project with 5 villages and Bantwal project with 7 villages in their wings have so far successfully flew and extended their services to 3323 families with a population of 19, 565 and attained the target set aside for total human development task, keeping in view the ideas and convictions of Primary Health Care.

The equilibrium on the axis "Heal and Comfort" motto of our Institutions is well maintained with the WHO theme "Health for All - All for Health". This has added a newer dimension to the people's movement. Does it appear to be a myth? Probably a visit will convince you.

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Total Health Care, the Tata Tea Model

BY

Sq. Ldr. V. SURESH

Total health care is the health policy of Tata Tea Limited. This integrates the curative, preventive, promotive and rehabilitative aspects of medical care, with equal stress on each. This paper is a broad review of the progress made by us in this endeavour, in this remote and rural area, within a short span of four years viz 1984 - 1988.

These hills adorned with tea are in the High Ranges of Kerala at an elevation between 4300 - 6200 ft. (1300 to 1900 mtrs). The annual rainfall varies from 130 cm in the east to 800 cm in the west. The land is rich in natural beauty, with forests, grass lands and rivers. These hills are a refuge haven and sanctuary for vanishing species of flora and fauna. Rajamallay is the home of Ibex, the Nilgiri Tahr, an endangered species. This borders the Eravicolam National Park. The Aneimudi, the highest peak south of the Himalayan Range, rises in the horizon to a majestic 8841 feet.

The Company has 24 adjacent tea estates. These cover an area of 500 sq. kms. Tea plantation began on these hills nearly 100 years ago, mainly by the Kanan Devan Hill Produce Co., which later became Tata Finlay Ltd. In 1983 Tatas assumed complete management and the company became Tata Tea Limited. The basic harvest of a bud and 2 tender leaves below is the most important work in field. Almost half the pluckers are women. The green leaf is made into black tea, of the Orthodox and CTC variety, at a tea factory. The Company has 17 factories in the High Range, including a Super factory.

The workers live in units called labour lines. There is a permanent work force of about 25,000 and a net population, including dependants, of 69,000 The housing units have water supply electrification and sanitation. The workers are migrants from adjoining Tamilnadu anq presently 3rd and 4th generation workers continue the task.

The man power and infrastructure of the medical department is four doctors, nurses, welfare officers and para medicals fan out to educate and implement immunisation, nutrition, water and environmental sanitation, maternal and child health, family planning and health education. You may also observe that the doctor, nurse and

hospital bed ratios visa-vis population are very optimal and exceed the dreams of the health planners of our country.

The General Hospital (G.H) at Munnar is the fountain head of all of our endeavour. The hospital, built around 1924, was providing only very basic services upto 1984. Since 84, it has been steadily updated and provide today curative services of very high quality. It is a 125 bedded referral hospital for 32 of our peripheral hospitals and dispensaries. Being the only major hospital in the area, it also meets the special needs of the non-Company population. Today the General Hospital has all speciality departments and supporting services. It is also a training centre for medical and para medical personnel. The hospital has attracted young, well trained and experienced specialists and has succeeded in motivating them to stay on and build up their departments.

The outpatient services are comprehensive. The Poly Clinic wing of the hospital has access to doctors' Chambers, laboratory, X-Ray, ECG and dispensary. Same day investigations are arranged for the workers who come from far away. Slide shows the Cardiac Clinic in progress. This Clinic monitors the treatment of 276 patients with Rheumatic and Congenital heart d sease and is the only such Clinic in the State outside the Medical College Sector.

The unique feature of all wards is a high turn over. Acute care and in vestigations are done at General Hospital. The stabilised patient is transferred back to estate hospitals where the care continues under supervision of Medical Officers. Today the hospital is self-sufficient, with no need for referral to distant centres except in the case of cardiac and neuro-surgery. The General Hospital today is a modern surgical centre where Gastro-intestinal, General, Orthopaedic, Plastic and Cancer Surgery is done besides Gynae, ENT and Eye Surgery. Slide shows eye surgery in progress. Upper G.I. fibre optic endoscopy was begun in December 86 and has conducted 300 endoscopies till June 1988. Special mention must be made of the operative performance of the department of Gynaecology and Obstrics.

Among the major services the Intensive Coronary Care unit stands out. This unit, equipped with 2 bed side monitors, portable DC defibrillator and ventilator is the only I.C.U. in the plantation district. The unit commissioned in August 1985, has treated 51 patients with acute myocardial infarction and lost only 4 with medically irreversible complications. The premature baby unit, commissioned in 1984 with 2 incubators has nursed 206 infants. To prevent this unfortunate predicament, an intensive effort is on in the field for efficient ante natal care and detection of high risk pregnancy.

The dental surgery unit has a demanding task due to the poor hygienic practises prevalent in the area. Nearly 4,000 cases are treated in an year.

The laboratory is fully updated and can undertake all investigations. The lab has

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an inter laboratory quality control survey with C. M. C. Hospital, Vellore. The bacteriology section undertakes cultures and antibiotic sensitivity tests.

A fixed and portable X-Ray unit meet an annual work load of approximately 3500 X-Ray exposures,

The medical store is guided by modern principles of management. Drugs are judiciously chosen for their proven scientific merit. Close monitoring of their movement prevents over stocking or under utilisation. Discipline in prescribing and avoiding poly pharmacy has enabled the store to stack all essential and life saving drugs in adequate quantity.

To keep a young team of doctors alert and satisfied, we have a dynamic "Continuing Medical Education" Programme. The Library has several national and in ernational journals and has a liberal fund. A monthly "Journal Club" reviews all recent and useful papers. We also publish our own quarterly journal "The Tata Tea Medical Bulletin" which goes to all doctors and nurses of the habit of scientific writing. We have presented over 10 papers in national conferences.

The modern conference hall has all audio visual facilities. We hold a monthly clinical seminar for all doctors and once in three months full day update session for nurses.

We have hosted one state and one national conference. The International College of Surgeons (Indian Chapter) Central and South Zones met at Munnar on 15th May, 1988.

ESTATE HOSPITALS

We have 32 estate hospitals and dispensaries, each manned by a doctor, nurses and para medical staff, with a total bed strength of 465. Each estate hospital has its own operation theatre where minor surgery and Family Planning operations are undertaken.

COMMUNITY DEVELOPMENT & SOCIAL WELFARE (C D & S W)

The main thrust of the Company in the preventive, promotive and rehabilitative field has been through the C D & S W Scheme, launched in December 1984. The Chief Medical Officer has a doctor in charge of the scheme, assisted by Welfare Officers who are Masters Degree holders in Social Welfare. A unique tool designed for the success of the venture is the "link worker", a vocal, influential and highly motivated worker who has voluntarily elected to serve as an effective and well informed link in communication between the health team and the labour. Estate Manager, Medical Officer and Welfare Officers have several formal and informal meetings with the link workers.

The health exhibition is an innovative and attractive medium designed to summarise the principles of health education. It has various sections. It moves from estate to estate.

Healthy Baby contest in progress during Health Exhibition. The criteria are :

1. Attendance at ante natal clinic.
2. Hospital delivery.
3. Immunisation.
4. Creche attendance.
5. Knowledge of mother about feeding and nutrition.

A socio-drama on the adverse effects of alcohol.

T. V. is also used as a medium to spread the message of health. Each estate has community halls equipped with T.V. and V.C.R. The Company has made its own tele-films on CD & SW and health and productivity.

Water Supply : The far flung plantation district has over 240 water points. Provision of potable water is a stupendous task. This is met by prevention of contamination, chlorination and careful delivery of water to the worker through pipes.

The child is looked after in the Creche when the parents are away at work. Company has 130 Creches where trained attendants take care of the infants.

Nutritious feeding is ensured in these creches, under close supervision of doctors and welfare officers.

Several of the infant care activities of the medical team centre around the creche. Regular medical examination is carried out. Regular weight monitoring is done and a road to health chart monitors nutrition, growth and development. III. malnutrition, a scourge in the past, has been virtually eradicated. Stress is on locally and economically available foods.

100% immunisation against vaccine preventable diseases has been achieved.

Company runs about 60 schools and school health is cared for by our doctors.

50% of workers are females. Maternal welfare is promoted by ante natal and post natal clinics at estate hospitals, identification of high risk pregnancies and their delivery at General Hospital, encouragement of hospital deliveries and correction of anaemia, malnutrition and hypertension in the mother.

Hospital delivery is encouraged. An incentive kit shown in the slide is an added attraction. Today 95% of our deliveries occur at hospitals.

We have popularised family planning with confidence. Temporary and permanent methods are encouraged. Imaginative slogans, as shown in the slide, catch the eye of the people. 67% of our eligible couples have accepted sterilisation. National target for 2000 A.D. is 65%.

CONCLUSION

Our all round efforts have achieved significant returns as evident in tde ensuing display of our health statistics.

Our birth rate of 18.5/1000 has already crossed the national target of 21/1000.

Our death rate 3.72/1000 reflects the effects of the total health care.

Out Infant mortality rate of 43.7/1000 is at per with Kerala State (42.5/1000) who has the lowest in the country.

Our Matetnal mortality tate of 0.54/1000 is negligible,

We also offer medical support to tribals and non company population. Muthuvans are the original inhabitants of these hills and the Company has a moral responsibility to lookafter their welfare. Slides show a long treak to the Kudi by estate manager and medical officer and subsequent medical examination and treatment.

I thank you for your patient and encouraging listening to this accounr of our efforts in the High Ranges. In an Urban Centre, this endeavour and results are easily achievable. But in the remote and rural hills of the High Range it has been an uphill task I hpoe. that you will encourage and appreciate this quantum leap achieved in the standard of medical care in the plantation sector. The concept of "Total Health Care" was born out of the courage of conviction, deep social commitment and the indefatigable will of Tata Tea Limited who has enshrined "human resource development" in the citadel of Company's policy.

(The presentation was illustrated by Seventy Eight slides)

DISCUSSION

This Session was chaired by Dr. B.D. Miglani who congratulated the Best Essay Awardee Dr. Mrs. Tripta Bhasin for her excellent presentation on the main theme of this Workshop on Hospital and Primary Health Care (PHC). Sq. Ldr. V. Suresh while answering the question of Dr. Bhadkamkar said that link workers bring forward useful link between management and the people at large. The link workers are voluntary workers and they meet medical officers every week and no special training or incentives are given to them. There were in 1988, twenty link workers. The population covered by the Tata Tea Model is small. For the selection of Link Workers, we do not face any problem. He also mentioned that all deliveries are conducted in hospital and, therefore, no Traditional Birth Attendants (TBA) are required. The others who took part were Mr. S. S. Mohsin,

Ranchi, Dr. S.S. Rikhy, Dr. T. G. Ramamurti, Mrs. S. Kareemunnise, Principle college of Nursing Visakhapatnam, and Dr. N. A. Siddiqui from Aga Khan Foundation, New Delhi. They dicussed the role of voluntary organisations, corporate health care institution, role of nursing, linkage of nursing with medical colleges etc. Dr. N.A. Siddiqui from Aga Khan Foundation of New Delhi mentioned money as a crucial input for motivating and ensuring commitment and people's participation for achieving the goal of PHC. The Chairman thanked all the Speakers particulary Dr. Mrs. T. Bhasin Assistant Commissioner for giving the total aspect so beautifully and comprehensively of health care and hospital involvement, and to Sq. Ldr. V. Suresh, Tata Tea Model-Munnar, Kerala for having given a good report supported by slides for Tata Tea Model and to Lt. Col. (Miss) C. Thiagarajan Principal Fr. Mullers Hospital Mangalore who described the work of voluntary Health Organisations in a dramatic way.

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22. 8. 1988

Scientific Session III

CHAIRPERSON

Dr. S.M. Bhadkamkar
Joint Director of Health Services
(Medical), Maharashtra,
Bombay (India).

SPEAKERS

1. Electronics in Primary Health Care (PHC).
   Mr V.K. Bhatia,
   Department of Electronics,
   Government of India,
   New Delhi (India).

2. National Requirements for Planning
   Community Health Centres (CHC).
   Mr. D. K. Agrawal,
   Bureau of Indian Standards,
   Bureau of Indian Standards,
   New Delhi (India).

3. Organisation of Ambulatory Care in an Autonomous Body :
   University of Delhi, South Campus - A detailed report.
   Dr. Pravin K. Verma,
   University of Delhi, South Campus,
   New Delhi (India).

4. Primary Health Care (PHC).
   Mr. S. S. Mohsin
   National Institute of Mental Health,
   Ranchi, Bihar (India)

5. Implementing People's Attitudes
   towards health through effective
   information and communication.
   Mrs. Reeva Sood,
   Consultant,
   Asian Centre for Organisation Research
   and Development, New Delhi (India).

Electronics in Primary Health Care

BY
DR. P.N. GHEI, MR. T.C. GUPTA, MR.V.K. BHATIA*

INTRODUCTION

Creating health care facilities for all citizens is a major goal before any nation. In the past the emphasis has been on a few specific diseases which have a fatal outcome. Presently our National health policy seeks to provide promotive, preventive, curative as well as rehabilitative health care to people so that quality of life is better. Since in India, majority of the people reside in semi-urban and rural environment, Primary Health Care is of crucial importance and is the most important tool for achieving Health for all by 2000 AD.'

In India, Health Care delivery system is provided through (i) Primary Health Centres (PHCs), (ii) Rural Hospitals (iii) District level Hospitals, and (iv) Major City Hospitals. There are 9000 PHCs in the country and the number of PHCs are expected to go up to 30,000 by 2000 AD. Each PHC caters for 30,000 population.

Primary Health Care Package

Application of Electronics in providing Primary Health Care for rural masses has been identified as one of our priorities Electro-medical instruments are making substantial contribution in improving the present day health Care delivery. Department of Electronics which is the nodal agency of Government of India in the promotion of Electronics in the various fields including Health & Medical Care, after detailed discussions with Ministry of Health, Directorate General Health Services (DGHS) and Indian Council of Medical Research (ICMR), identified a package of 19 equipment which would form the essential complements of medical equipment needed for Primary Health Care at PHCs. The package consists of the following :-

1. Weighing Machine for New Born/Infant.
2. Blood Pressure Measuring Instrument.
3. Colorimeter.
4. Centrifuge.
5. Haemotocrit.
6. Haemoglobinometer.
7. Microscope.

*Department of Electronics, New Delhi presented the paper

8. Labstick for Urine Testing.
9. Autoclave.
10. Instrument Sterilisation Unit.
11. Pregnancy Detection Unit.
12. Simple Telethermometer
13. Solar Refrigeration Unit.
14. Audio Visual Aids.
15. Wireless Communication Equipment.
16. X-ray Unit.
17. Data Entry System.
18. Cold Chain.
19. Water Tubewell pump (electricity/ solar operated.

It may be seen that the package, in addition to medical equipment required for diagnostic purposes. also includes electronic equipment like Data Entry System, Wireless communication system, Audio visual Aids etc. for effective health education & preventive care. This package is selected keeping in view the eight important ingredients of primary health care i.e. Nutrition, Clean drinking water, basic sanitation and hygiene, M.C.H. & Family Welfare, immunisation against six vaccine preventable diseases, prevention of locally endemic disease, health education and appropriate treatment for injuries & illnesses.

Action Plan for Implementation of Pilot Project

With a view to ensure availability of a well identified & field tested package for induction to Primary Health Centres, following action Plan was decided to achieve the objectives:-

a) To get a quick and thorough survey of what is available with reference to the items identified for the PHC package.

b) Simultaneously with the above, requirements in terms of performance specifications, engineering specifications and financial requirement for each item keeping the specific need of Primary Health Centres in mind.

c) While the above two exercises are being done, the gap between the requirements on one hand and what is available on the other would emerge and should be properly codified and detailed. Also some of the equipment available though not fully upto the requirement, may have to be obtained from indigenous source or through import and these should be evaluated in field conditions.

Based on this action plan, a project was launched with ITT Delhi with the following objectives :-

a) Identifying suitable equipment already manufactured in the country.

b) Drawing detailed specifications and financial requirement of each item.
c) Development and adaptation of the equipment if not available readily.

Out of these 19 items, 12 identified equipment were found to be available indigenously off the shelf in the market. These equipment are being field tried in 21 PHCs (4 PHCs in Phase I and 17 in Phase II) located in different geographical regions with varying environments of the country e.g. in the rain drenched areas, in hot and dusty deserts, in hilly areas etc. A list of PHCs selected for field trial is given as Annexure I in the end. The main objectives of the trial are :

(a) To assess the suitability of these equipment in primary health care at PHCs.
(b) To study the equipment from hardware angle viz. functioning & effectiveness.
(c) To collect the feed-back for taking subsequent decision for expansion of the scheme.

The trial is a crucial step prior to the implementation of the scheme on a wider scale. We have started getting feed-back from these Centres which is very encouraging. Remaining equipment are being developed in the country in the premier R & D institutions (See Annexure II). The equipment developed will meet the special requirement and specifications of PHCs such as :

(1) The equipment should be rugged, easy to operate and service.
(2) It should be of standard & tamper proof design.
(3) It should be battery/AC mains operated with built in safety and possible solar back up.
(4) It should take care of the requirement of region based software as regards to health information of the country. These developed equipment will also be field tested.

Scope of the Project

The project aims to establish trial units, to begin with at 21 PHCs (in two Phases) located in different parts of the country. At each PHC 12 equipment identified for primary health care have been provided. Staff of the PHCs have been trained in respect of operation of the equipment. A monitoring team constituted with a member each from Department of Electronics, Directorate General Health Services and I.I.T. Delhi maintains close contact with the staff of the PHCs and solve whatever problems that arise and also obtain feedback regarding the experience in the use of equipment package. At the end of the one year period of field use of the package, recommendations based upon the experience would be presented for taking up the programme in a wider scale.

Feedback Received so far

Monitoring Team has prepared an Interim Report based on the inputs collected over a period of six months. The report gives an encouraging picture on the utility of the

package. It was found that practically no pathological tests were carried out at Centres prior to the supply of the package. It has been pointed out that after the induction of the package and its usage, the faith of local population in PHCs has tremendously increased. No more the local people have to travel to long distances for common pathological tests. Barring photo-electric colorimeter, all other equipment have been extensively used by the doctors and the para-medical staff. No major failure of the equipment was reported during the course of this study. However, during various visits to these PHCs, the correct procedure and the working of some of the equipment had to be explained, minor repairs were attended and precautions to be taken were explained, to the PHC staff.

Following are the recommendations with regard to monitoring of the field Trial and ground work required for the expansion of the scheme on regular basis :—

1. The doctors and the laboratory technicians need to be trained in proper use, handling and preventive maintenance of the equipment in the package.
2. There is a necessity to have a "On the Job Training" at site at the initial stages till the PHC is fully geared for successful implementation of the scheme.
3. Though no major failures were reported, there is a need to strengthen repair and maintenance set up and expand it right upto PHC level. This is to be sorted out before the package is introduced on regular basis.
4. All the equipment were found to be very useful by PHC staff and their inclusion in the package is strongly recommended.
5. PHC staff was enthusiastic about the remaining equipment those are under development. They opinioned that equipment like portable x-ray machine, Audio visual aids, data entry system, Electronic weighing machine etc. will further enhance the capability of PHC with regard to basic health care of rural masses.
6. Continuous and regular supply of consumables needs, to be ensured for the effective use of the equipment before the scheme is introduced on regular basis. This aspect needs to be institutionalised.

CONCLUSION

The feedback so far received is based on the inputs from the PHCs taken up in the first Phase. Equipment for the PHCs included in the 2nd Phase have been installed only in March 1988 and more feedback will be available in another 6 months to 1 year period of time. Before a final conclusion is arrived at regarding the induction of this package on regular basis, a thorough study of the data available from all the 21 PHCs to be made. The equipment which are not indigenously available (and are being developed presently at IIT Delhi and CSIO Chandigarh) need also to be field tested for their suitability and utility on the same pattern as being done for indigenously available equipment. It is expected that a well identified and field tested package which will form the essential complement of health care equipment at PHCs will be available by 1990.

ANNEXURE—I

List of PHCs Selected for Introduction of Electronics in the First Phase

State/U.T.	Name of PHC	District
1. West Bengal	Sagar	24-Parganas
2. U.P.	Bhimtal	Nainital
3. Rajasthan	Pisangan	Ajmer
4. Delhi	Palam	Delhi

List of the PHCs Selected for Introduction of Electronics in the Second Phase

1.	Andhra Pr.	Maddipadu	Prakasam
2.	Assam	Manikpur	Goalpara
3.	H.P.	Paddar Jogindernagar	Mandi
4.	Karnataka	Kaiwara, Chintamani Iq.	Kolar
5.	Maharashtra	Phulumari	Aurangabad
6.	T. Nadu	Periyapalayam	Chengelpet (N)
7.	Orissa	Boriguma	Koraput
8.	Sikkim	Phodong	North Sikkim
9.	T. Nadu	Chinnthagampatty	Dharmapuri
10.	Tripura	Manu	North Tripura
11.	W. Bengal	Gopiballavpur	Midnapura
12.	A & N	Winberilugul	
13.	Goa	Sanque	
14.	P Cherry	Kalapet	
15.	Rajasthan	Kolayat	Bikaner
16.	U.P.	Gurusarai	Jhansi
17.	U.P.	Awagarh	Etah

ANNEXURE—II

A. List of PHC Equipment Taken up for Field Trial

1. Weighing Machine for New Born/Infant.
2. Blood Pressure Measuring Instrument.
3. Colorimeter.
4. Centrifuge.
5. Haemotocrit.
6. Haemoglobinometer.
7. Microscope.
8. Labstick for Urine Testing.
9. Autoclave.
10. Instrument Sterilisation Unit.
11. Pregnancy Detection Unit.

B. List of Equipment taken up for Development By IIT, Delhi & CSIO Chandigarh

1.* Weighing Machine for New Born/Infant.
2. Simple Telethermometer.
3. Solar Refrigation Unit.
4. Audio Visual Aids.
5. Wireless Communication Equipment.
6. X-ray Unit.
7. Data Entry System.
8. Autoanalyser Combining Colorimeter and Haemoglobinometer.

* Trial will commence with the indigenously available equipment. Better version will be developed which would be tried out subsequently.

National Requirements for Planning of Community Health Centres

BY

MR. D. K. AGRAWAL*

INTRODUCTION

0.1 In 1978 the International Conference on Primary Health Services in Alma Ata identified primary health care as key to Health For All. One of the important concept was to provide health care for prevention of diseases, health promotion, curative and rehabilitative services. India has taken a leading role in providing the health care facilities at the community level and has put a target of 'Health for all' by the year 2000 A.D. The country at present, has nearly 7000 hospitals with over 5 00 000 beds with a bed population ratio of 0.7 bed per 1000 population. National Health Policy (1983) has laid guide-lines towards comprehensive and integrated approach to development and strengthening of National health care infrastructure. Primary health care has been adopted as the principal instrument of action. With this objective in mind, the Govt. of India in its Eight Five Year Plan has anticipated to have more than 5000 community health centres which should be able to provide the Primary health services to the community. These centres would be identified as the first referral centres.

1. National Requirements

1.1 The Community at large has certain requirements pertaining to their health and hygiene. The community health centres to certain extent fulfil their requirements. These requirements when put in a document form become code/guideline/specification. When the requirement are universally accepted by the nation, they become national requirements or in other words the national standard.

2. Procedure for Formulation of National Standards

2.1 For preparing the national standards on hospital planning, there is a technical committee, i.e., Hospital Planning Sectional Committee, CPDC 38, which consists of experts from disciplines of hospital administration, hospital planners, architects, and technical experts from various other disciplines. The Committee is headed by its chairman, Dr. Harcharan Singh, Advisor, Health and Family Welfare, Planning Commission. The Committee had a Programme of Work to formulate standards for planning of various categories of hospitals including physical, space, staff, equipment and building requirements. The preliminary draft is prepared with the assistance of the technical experts

Bureau of Indian Standards, New Delhi

which forms the basis of discussions at the technical committee meeting. The draft after modification is circulated to all the interests in the country and abroad. The Committee modifies the draft considering the comments received and finalizes it for publication.

3. Indian Standard for Basic Requirements for Hospital Planning Part 1 Upto 30 Bedded Hospital

3.1 This Indian Standard is mainly meant for the community health centres of bed compliment upto 30 beds. It includes requirements such as functional programme, functional area, work flow, manpower, instruments and equipment. Certain essential requirements for building, services and environmental have also been included.

Since no single standard can meet requirements of different regions in the country representing plains, hilly terrains and diverse geo-climatic variations, an attempt has been made in the standard to cover minimum needs for a 30 bedded hospital which could be suitably adjusted to meet specific needs and priorities of a particular region or community.

3.2 Functional Programme-A 30 bedded hospital should have the following facilities;

Group 1 : Medical and Allied Disciplines

Code	*Nomenclature*	*Including*
1 01	Anaesthesiology	
1 13	Community Medicine	Preventive and Social medicine
1 14.1	Emergency Medicine	
1 15	Dentisry (Optional)	
1 29	General Medicine	Internal Medicine
1 30	General Surgery	
1 64	Obstetric and Gynaecology	
1 72	Paediatrics	
1 74	Pathology (Optional)	
1 88	Radio Diagnosis	Radiology

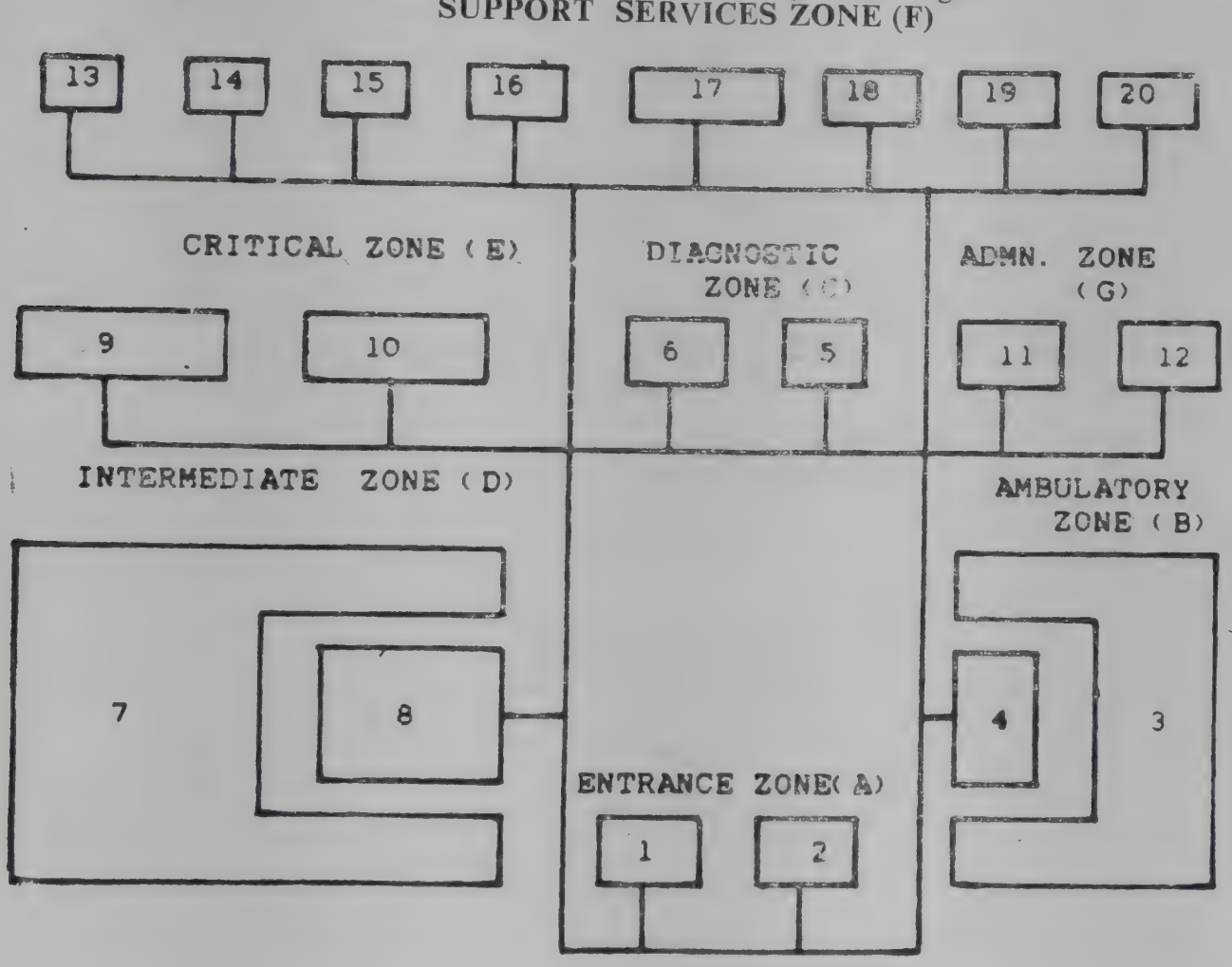
Group 2 : Health and Allied Services

2 20	Family Welfare
2 25	Health Education
2 45	Maternal and Child Health
2 50	Nutrition
2 70	School Health

	Group 3: Nursing, Paramedical & Allied Services	
3 05	Dental Technology (Optional)	Dental Hygienc (Optional)
3 10	Dietetics & Therapeutics (Optional)	Catering (Optiopnal)
3 15	Drugs and pharmacy	Blood bank
3 20	ECG Technology	
3 30.1	X-ray Imaging	
3 30.2	Ultrasound Imaging	
3 35	Laboratory Technology	
3 40	Laundry Technology (Optional)	
3 45	Medical Record Technology	
3 47	Medical Social Work (Optional)	
3 50	Nursing Services	
3 55	Operating Theatre Technology (Optional)	Anaesthesia Technology
3 60	Opthalmoic Technology	
3 90	Sterilization & Disinfection Technology	CSSD Technology
	Group 4 : Engineering & Allied Services	
4 05	Building Maintenance	
4 10	Electric Supply	Power Generation & Stabilization
4 15	Fire Protection	Alarm system
4 24	Horticulture (Optional)	Landscaping
4 35	LPG Supply (Optional)	
4 40	Mechanical Transport	Ambulance Service
4 45	Medical Gases Supply & Vacuum (Optional)	Scavanging
4 47	Refrigeration	
4 50	Sewage Treatment & Disposal (where required)	Sanitation and drainage
4 52	Solar Energy (Optional)	
4 55	Solid Waste Disposal	Incineration
4 60	Telephone & Communication	Paging
4 65	Water Treatment & Supply (where required)	Plumbing
4 70	Workshop (Optional)	
	Group 5 : Administrative & Ancillary Services	
5 05	Audio-visual Services	Field Publicity
5 35	General Administration	

5 40	House Keeping	
5 45	Library	
5 55	Materials Management	Inventry Control
5 75	Security	

3.3 Functional and Area Requirements—The total area to be provided for a hopsital complex shall depend on the availability of land. However, for guidance an area of one acre or more has been recommended for 30 bedded hospital. The hospital site with high degree of sensitivity to outside noise should be avoided. The residential accommodation for the essential staff, which includes resident medical officer, nurses and class four staff should be provided. For the relative of patients, some accommodation like shelter homes may also be provided. A typical work flow analysis is given in Fig. 1.



1. Reception/Registration
2. Pharmacy
3. Examination/Consultation
4. Nursing Station
5. Clinical Laboratory
6. Imaging
7. Patient Area
8. Nursing Station
9. Operating Theatre
10. Labour Room
11. General Administration
12. General Stores
13. Manifold
14. C. S. S. D.
15. Laundry
16. Kitchen
17. Sub-Station
18. Workshop
19. Mortuary
20. Incinerator

Figure 1—Workflow Analysis, 30 Bedded Hospital

3.3.1. Functional and Area Analysis

3.3.1.1. The recommended functional and area analysis shall be as given in Table 1.

Table 1 Functional & Area Analysis for 30 Bedded Hospital
(Clause 8.1)

Zone	*Functions*	*Area/Bed* m^2	*Total Area* m^2
(1)	(2)	(3)	(4)
Entrance Zone		2	60
(A)	Reception & Registration —Reception Counter —Record Storage Pharmacy —Issue Counter —Formulations —Drugs Storage Public Utilities Circulation Space		
Ambulatory Zone (OPD)		10	300
(B)	Examination & Workup —Examination Rooms —Sub-Waiting Consultation —Consultation Rooms —Toilets —Sub-waiting Nursing Station —Nurses Desk —Clean Utility —Dirty Utility —Treatment Rooms Injection and dressing ECG —Sub-waiting Casualty/Emergency Public Utilities Circulation Space		

Diagnostic Zone (C)	Pathology (Optional) —Laboratory —Sample Collection —Bleeding Room —Washing/Disinfection —Storage —Sub-waiting Imaging (Radiology, Radiography, Ultra sound) – Preparation —Change —Toilet —Control —Dark Room (Film developing & processing) —Treatment room —Sub-waiting Public Utilities Circulation Space	6	180
Intermediate Zone (Inpatient nursing Units) (D)	Nursing Station —Nurses Desk —Clean Utility —Treatment room —Pantry —Store —Sluice room —Trolley Bay Patient Area —Bed Space —Toilets —Day space —Isolation Ancillary Rooms —Doctor's Rest Room —Nurses Duty Room Public Utilities Circulation Space	25	750

Critical Zone (Operation theatre/Labour Room) (E)		8	240
	Patient Area		
	—Preparation		
	—Pre-Anaesthesia		
	—Post operative resting		
	Staff Area		
	—Changing		
	—Resting		
	Supplies Area		
	—Trolley Bay		
	—Equipment Storage		
	—Sterile Storage		
	O. T./L. R. Area		
	—Operating/Labour Room		
	—Scrub & Gown		
	—Instrument Sterilization		
	—Disposal		
	Public Utilities		
	Circulation Space		
Service Zone (F)		7	210
	Dietry		
	—Dry Store		
	—Day Store		
	—Preparation		
	—Cooking		
	—Delivery		
	—Pot Wash		
	—Utensil Store		
	—Trolley Park		
	C.S.S.D.		
	—Receipt		
	—Wash		
	—Assembly		
	—Sterilization		
	—Sterile Storage		
	—Issue		

	Laundry —Receipt —Weight —Sluice/Wash —Hydro-Extraction —Tumble —Calender —Press —Clean Storage —Issue		
	Civil Engineering —Building maintenance —Horticulture —Water supply —Drainage & sanitation		
	Electrical Engineering —Sub station & generation —Illumination —Ventilation		
	Mechanical Engineering —Air conditioning —Refrigeration		
	Other Services —Gas supply —Telephone & intercomm —Fire protection —Waste disposal —Mortuary		
Administrative		2	60
Zone (G)	General Administration General Stores Public Utilities Circulation Space		
	TOTAL	60	1,800

3.4 **Manpower Requirements**—In the beginning when the hospital starts functioning, it is recommended that the total strength should be based on 2 persons per bed but should be increased to 3 persons per bed when the hospital is working to its full load capacity. Given below is the recommended strength :

		Min
3.4.1	**Medical Staff**	
	—General Medicine	1
	—General Surgery	1
	—Obstetrics & Gynae	1
	—Paediatrics	1
	—Anaesthesiology	1
	—Dentist (Optional)	1
	—Pathologist (Optional)	—
	—Radiologist (Optional)	—
	—General Duty Medical Officers	3
	—Community Medicine	1
3.4.2.	**Health Staff**	
	—Female Health Assistant	1
	—Extension educator	1
	—Nutritionist (Optional)	—
	—Public Health Nurse (Optional)	—
3.4.3.	**Nursing Staff**	
	—Matron	1
	—Operating Theatre Nurse	1
	—Labour Room Nurse	1
	—General Nurse	7
	—Nursing Aides	7
3.4.4	**Paramedical Staff**	
	—Pharmacist/Asst. Pharm.	1
	—Dietician/Asst. Diet (Optional)	—
	—Technologist/Technician ECG (Optional)	1
	—Technologist/Tech. Imaging	1
	—Technologist/Clinical Path/ Haematology/Blood Bank	1
	—Technologist/Laundry (Optional)	1
	—Technologist/Med. Records	1

—Technologist/C S S D	1
—Technical Aides	5
—Technologist opthalmology	1
—Technologist, Dental	1
3.4.5. Engineering Staff	
—Technologist/Technician Elec.	1
—Technologist/Mechanical/Plumbing	1
Engineering Aides	2
3.4.6 Administrative & Ancillary Staff	
—Stenographer	1
—Store Keeper	1
—Admn. Assistant	1
—Telephone Operator/Telex Operator	1
—Driver	1
—General Attendants	2
—Security Attendants	4
—Sanitary Attendants	5
	63

3.5 **Instruments and Equipment**—The standard specifies the instruments and equipment required in a 30 bedded hospital according to the various zones as given in the workflow analysis. Reference to the equivalent Indian Standards is given for all the instruments and equipment, wherever the standards are available.

3.6 **Building Requirements**—The building requirements such as circulation areas, floor height, architectural finishes, sanitary fitments etc are specified. The building requirements include the requirement for OPD clinics, ward units, imaging, water supply, illumination, fire protection, waste, disposal system, central sterilization, dietary services and laundry services.

Organisation of Ambulatory Care in an Autonomous Boby : University of Delhi, South Campus—A Detailed Report

BY

DR. PRAVIN K. VERMA

INTRODUCTION

The University of Delhi was established in the year 1922. To provide medical care to the employees, their family members and the students, a small health centre was established in the year 1955 with the help of World University Service, a non-political International Organisation.

With time, the University community grew and so did the number of colleges affiliated to it, scattered throughout Greater Delhi. Now the University has approximately 730 teaching, 2,800 non-teaching employees and about 18,000 students attached to various faculties and postgraduate departments. The 64 colleges affiliated to the University of Delhi have more than 1,00,000 undergraduate students with about 5,500 teaching and 5,000 non-teaching employees[1], [2]. Assuming that each family consists of five members, there are about 70,000 beneficiaries from the families of the teaching and non-teaching employees of the University and its affiliated colleges and the total number of beneficiaries, entitled to medical care, including University and college students comes to about 1,85,000.

To provide medical care to its beneficiaries, the University of Delhi has two schemes, and, an employee can opt for either of them.

1. **Reimbursement Scheme**—In this scheme medical consultation is provided by private practitioners, approved by the University in various localities. The consultation fees and the medicine bills are reimbursed. The scheme is open to employees only.

2. **Contributory Health Centre Scheme**—This scheme is open to both the students and the employees on contributory basis. Medical consultation, specialists services, all kinds of medicines and investigation facilities are provided by four health centres located in North, South, West and East Delhi Campuses of the University. The running cost of these four health centres is more than Rs. 38,39,000/- per year[3].

Hospitalisation Scheme—Any beneficiary requiring hospitalisation is referred by the medical officers of the health centres or the authorised private practitioners to hospitals approved by the University and the expenses incurred are reimbursed as per laid down rules.

University of Delhi, South Campus : Proposal for a Comprehensive Health Care Unit

For better administrative control of the colleges located in and around South Delhi, South Campus was established in the year 1973. Again the World University Service came forward to establish a health centre on part-time basis. A full time health centre was started by the University of Delhi at the South Campus on 2nd January, 1978.

With time, the Campus grew and need was felt to provide comprehensive health care to its 65 teaching and 175 non-teaching employees and their family members alongwith about 1,300 students attached to its various faculties and postgraduate departments. About 1,800 teaching and 1,200 non-teaching employees with their family members and over 30,000 students of the 25 colleges attached to the South Campus are also entitled for medical facilities, i.e., a total of about 47,500 beneficiaries.

To provide effective medical facilities to the beneficiaries of the South Compus, a detailed report was prepared. Keeping in view Objectivety in planning, Reliability in service and Flexibility in terms of future expansion, the following points were considesed :

1, **Aims and Objectives**—It was proposed that a comprehensive health care be provided with latest diagnostic techniques. Twenty four hour services with provision to deal with emergencies should be available.
Taking into account the age distribution of the employees, it was felt that there should be provision for an Intensive Care Unit and a four bed ward for patients under observation.

2. **Location**—The health centre would be located inside the Campus and will be easily accessible to the resident and non-resident employees and students of the campus and near about colleges. To be called accessible, it is required that 75% of the total population attending the OPD should be able to reach it within 20 minutes of travel time by conventional means and ideally an OPD should be able to reach it within 20 minutes of travel time by conventional means and ideally an OPD should be near a public road where public transport is easily available[4,5].

3. **Estimated Population to be served**—The centre is expected to serve a population of 16,000 (appx.). This estimate of beneficiaries has been worked out, keeping

in view the manifold expansion of the South Campus with proposed residential facilities for staff and students, increasing number of staff and students and a number of colleges shifting to their new buildings nearer to the South Campus. Details are presented in Annexure-I.

4. **Estimated OPD Attendance**—In urban area, it has been observed that a population of 1,000 generates 3,000 OPD visits per year.[6] However, this health centre would be situated in a residential campus consisting of literate class of people believing in regular medical check-ups and immediate medical attendance in case of any ailment. The students would be present in the campus from morning till late evening. And hence, it is expected that a population of 1,000 will generate about 5,000 visits, i.e., the expected OPD attendance would be over 80,000 per year. This estimation is also based on the fact that at the North Campus Health Centre a beneficiary population of about 51,000 has generated more than 2,90,000 OPD visits in the year 1985-86 and 1986-87, i.e., a ratio of about 1 : 6[7].

5. **Staff Requirement**—Hospital Equipment Standardisation Committee, 1963[8] and the Technical Report No. 5 of the NIHFW[9] have recommended staffing patterns for different sizes of hospitals. It is stated that one medical officer is required for a population of 3,000[6]. However, more staff would be required for this health centre as staggered OPD hours would be provided from 8.00 A.M. to 8.00 P.M. in two shifts with emergency services at night from 8.00 P.M. to 8.00 A.M. Sufficient staff for leave reserve and compensatory off for night duties will have to be maintained. For providing specialised services, specialists in various fields would be employed on part-time basis to visit the health centre in rotation, e.g., two hours each visit, three visits a week. The staffing pattern would be based on the functional requirements of the health centre. The proposed staff requirement is given in annexure-II.

6. **Space Requirement**—It has been recommended that the space requirement for an OPD should be about 1 Sq. feet per patient for the total annual OPD attendance, i.e., if the expected OPD attendance per year is 80,000, the total floor area available should not be less than 80,000 Sq. feet[10]. It has also been observed that work load in an OPD doubles up in 7 to 10 years, i.e., an increase by 10% every year[11]. Hence. there must be enough provision for expansion of the building [12], [13].

7. **Building Plan Guidelines**—"The building and its facilities must express the functions or activities to take place within—Form Follows Functions"[10], [14], [15]. A general guideline for extra and intramural facilities to be provided must be

prepared before submitting the architect's brief. In this paper only intramural aspect has been highlighted.

A. **Functional Area in an OPD**—There are three distinct functional areas in an OPD, Public Zone, Joint use Zone and Staff Zone and accordingly the following areas were identified for the proposed building :

a. **Administrative Area** - This area will include Chief Medical Officers room, Office, Stores, Seminar room, Reception and Medical Records room.

b. **Diagnostic Area** - This area is sub-divided into Consultation/ Examination rooms for general duty medical officers and specialists and facilities for X'Ray and Pathology Laboratory.

c. **Therapeutic Area** - This area is sub-divided into routine services like Pharmacy, Dressing, Injuction, Minor OT, Plaster room and Physiotherapy and the Emergency services of ICU and observation ward. The Autoclaving/CSSD room will also be located in this area.

d. **Civic Facilities** - Space for drinking water facilities, public and staff toilets, staff room, doctor's and nurse's duty rooms and a small canteen.

e. **Waiting and Circulation Area** - The waiting area should be planned keeping in view where the bulk patients are expected to wait and circulation system should not lead to cross trafficking.

B. **Availability of Essential services** - The following points were considered :

a. **Water** - About 340 Lts. of water/bed/day is required for a hospital of less then 100 beds and 450 Lts./bed/day for a hospital of more than 100 beds [5,16]. For an OPD it is required that continuous running water should be available.

b. **Electricity** - The usual requirement is 2 KW/bed/day[5]. A 50 KW line exclusively for the X'Ray unit is essential and sufficient electricity will be required for Pathology Laboratory, Dental unit, Autoclaving room and Minor OT apart from overall lighting system. There may not be regular requirement of this much electricity in an OPD but it should be available. A double grid system is advisable. The electrical wiring layout should be flexible enough to take care of new developments and changing technology of medical gadgets.

c. **Public Conveniences** - Public telephones, drinking water and toilets must be provided at proper places. A small subsidised canteen for staff and beneficiaries is also essential.

d. **Sewage Disposal** - About 450 Lts. of liquid discharge/bed/day is generated in a hospital[5]. In an OPD it is mainly through X'Ray unit, Dental unit and Minor OT and accordingly arrangements should be made.

e. **Garbage** - Hospital garbage (4-5 Kg. /bad/day) is highly infectious and should be incenerated.

f. **Communication** - The OPD should have telephone facilities and intercomm/ paging system for external and internal communication. A public address system is advisable.

C. **Layout of the Building** - Theoritically, the layout of an OPD can broadly be of three types : double loaded single corridor, double corridors with entrance from opposite sides, and triple corridors with two peripheral and one central staff corridor. However, the layout would depend upon the availability of land to plan horizontal or vertical structure. Various functional areas should be identified and located accordingly so that similar and closely related activities should be grouped together [17],[18]. Keeping in view our cultural background that a patient is generally accompanied by one or two attendants, suitable waiting space and civic facilities should be provided [5],[15]. Colour coated direction markers have been found to be useful. The general layout of the proposed building is given in Annexure III.

8. **Architect's Brief** - The functional desirability of the OPD with specific requirements of each facility to be provided should be submitted for architect to design the building. The Planning Team, consisting of Medical Administrator, Nurse Administrator, Hospital Architect, Hospital Engineer, Financial Expert, Health Statistician and also Social Scientist and Health Educationist, should co-opt specific specialist for particular Department. A complex institution like hospital/ OPD has special requirements for every department, however, for OPD special attention should be given to ICU, dental, ophthalmology and ENT rooms, X'Ray unit [19],[20],[21] and Pathology Laboratory.[22], [23]. The optimum requirement, for both spatial and environmental needs, have been recommended by Indian Standard Institution [21]. It has been noted that proper architectural plan can effectively reduce hospital/ cross infection [5], [18]. There must be clear-cut task definition to prevent development of inappropriate building. The plan must provide for flexibility for future expansion [17], [24], [25].

9. **Budget Requirement** - Establishment of a Comprehensive Health Care Unit with moderately good facilities will require initial capital expenditure on the building and equipments. It has been observed that the building construction cost alone account for about 50% of the total health care budget in developing countries[14] The proposed building of the South Campus Health Centre may cost about

Rs. 25,00,000/- or more, not taking into account the cost of land. A good X'Ray machine of 500 MA with accessories and dark room equipments will cost about Rs. 12,00,000/-. Other medical, surgical, dental, ophthalmic, ENT, gynaecological, pathology laboratory equipments, ambulance and other minor equipments and instruments will cost about Rs. 10,00,000/-. The office equipments including furnishing of the entire health centre may further need about Rs. 3,00,000/- to Rs. 5,00,000/-. However these are only approximations. The running cost will depend upon provision for various budget heads commensurating with the OPD attendance and thereby per-capita expenditure, type of facilities to be provided and the staff strength. An illustrative budget for the proposed health centre is given in annexure IV.

CONCLUSION

The enourmous value of an efficient Out Patient Department can not be over-emphasized. However, the most pressing issue faced by the Planners is to maintain a balance between providing effective service through latest diagnostic techniques and treatment and the financial implications involved. An Out Patient Department needs to be planned with a measure of adaptibility in its internal arrangments and substantial capacity for growth.

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ANNEXURE—I

ESTIMATED POPULATION TO BE SERVED

— Approximate number of staff members to be taken care of—Campus and College employees.	3,000
— Total number of beneficiaries from staff member families—Average five per family.	15,000
— Approximate number of resident students.	250
— Approximate number of non-resident students.	500
— Approximate number of ad-hoc/temporary employees.	100
— Approximate number of retired beneficiaries.	100
— Approximate Grand Total of all the beneficiaries.	15,950

ANNEXURE—II

TOTAL STAFF REQUIREMENTS OF THE PROPOSED HEALTH CENTRE

A. Medical Staff	
1. Chief Medical Officer	1
2. Medical Officers—(2 should be Lady M.O.)	
a. Senior Medical Officers	2
b. General Duty Medical Officers	4
3. Consultants—Part-time Specialists	
a. Cardiologist/Chest Specialist	1
b. Surgical Specialist	1
c. Orthopaedic Specialist	1
d. Gynaecologist	1
e. Ophthalmologist	1
f. Dental Specialist	1
g. ENT Specialist	1
h. Radiologist	1
i. Pathologist	1
j. Paediatrician	1
k. Psychiatrist	
B. Para-medical Staff	
1. Reception & Medical Records Room	
a. Medical Records Clerk	1
b. Receptionist/Attendant	2
2. Stores	
a. Stores Incharge (Pharmacist)	1
b. Stores Clerk	1
c. Stores Attendant	1

Annexure—II (Contd.)

3. Pharmacy/Dispensary	
a. Pharmacist	5
b. Male Attendant	1
4. Dressing Room	
a. Dresser	2
5. Injection Room	
a. Nurse Incharge	1
b. Staff Nurse	3
6. Minor O.T.	
a. Staff Nurse	1
7. I.C.U.	
a. Staff Nurse	2
b. Dresser/Attendant	2
8. Plaster Room	
a. Dresser/Attendant	1
9. Physiotheraphy	
a. Physiotherapist	1
b. Female Attendant	1
10. Clinical Pathology Laboratory	
a. Sr. Medical Lab. Technician	1
b. Jr. Medical Lab. Technician	1
c. Path. Lab. Attendant	1
11. X 'Ray Room	
a. Sr. X'Ray Technician	1
b. Jr. X'Ray Technician	1
c. Dark Room Assistant	1
12. Specialist Room (Gynae./Dental/Ophthal.)	
a. Staff Nurse	1
b. Dental Technician	1
c. Female Attendant	1

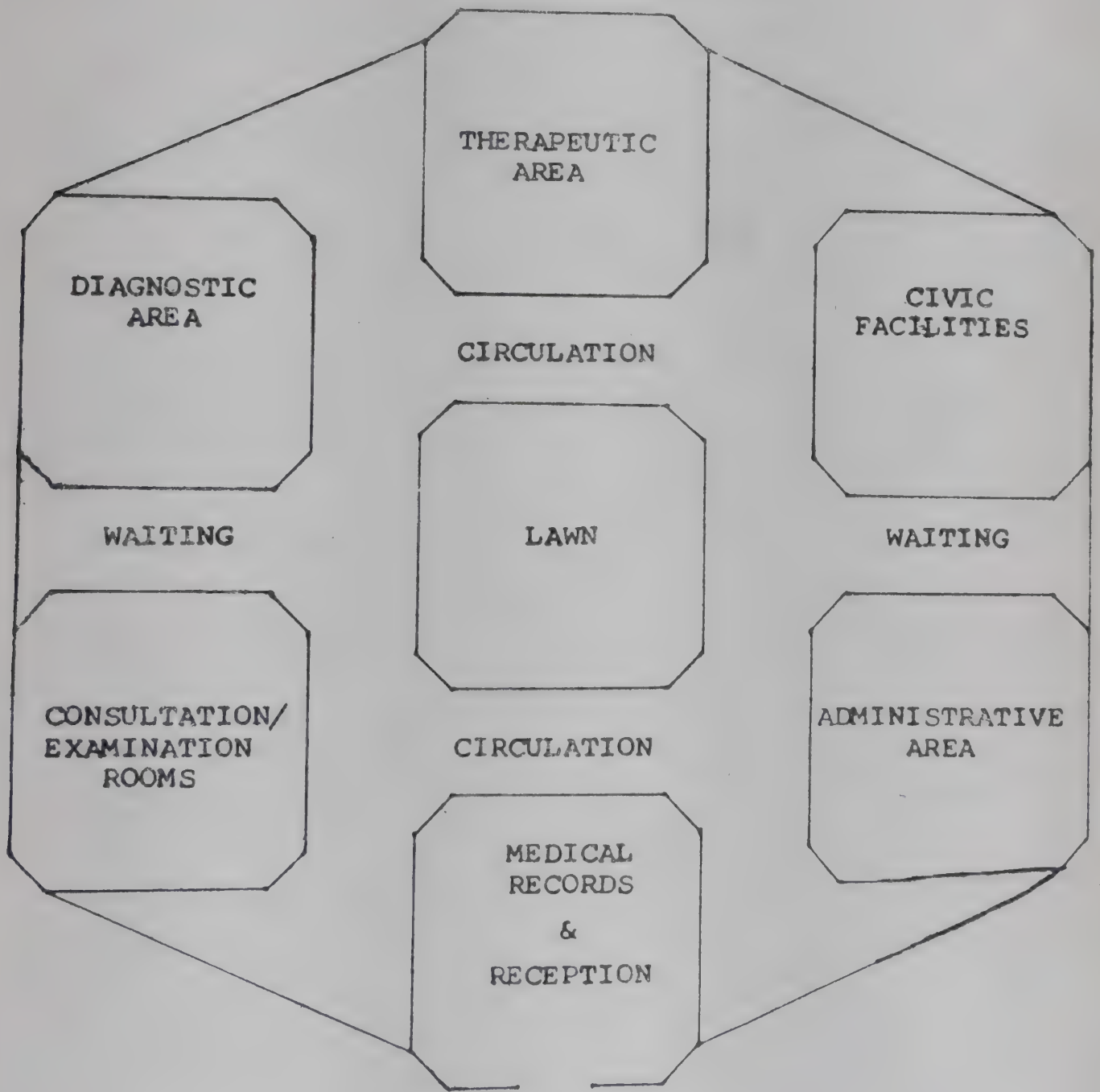
C. Office and Other Staff

1. Administrative Officer/Section Officer	1
2. Sr. Assistant	1
3. Jr. Assistant-cum-Typist	2
4. Peon	3
5. Safai Karamchari	3
6. Gardener	2
7. Watchman	4
8. Ambulance Driver	1

ANNEXURE—III

GENERAL LAYOUT PLAN FOR THE PROPOSED BUILDING

EXTRAMURAL FACILITIES



—Parking
—Canteen
—Ambulance garage
Waste disposal pit

—Electric generator/sub-station
—Water tank
—Residential facilities for essential staff

ANNEXURE—IV

ILLUSTRATIVE BUDGET OF THE PROPOSED HEALTH CENTRE

A. Non-recurring (Capital)		
a. Building	Rs.	25,00,000/-
b. Furniture & Equipments	Rs.	25,00,000/-
B. Recurring (Running)		
a. Medicines	Rs.	7,00,000/-
b. Laboratory Chemicals & Glasswares	Rs.	10,000/-
c. X'Ray Films & Chemicals	Rs.	10,000/-
d. Linen	Rs.	5,000/-
e. Furniture & Equipment		
— Medical	Rs.	10,000/-
— Non-medical	Rs.	5,000/-
f. Maintenance of Furniture & Equipment	Rs.	5,000/-
g. Contingency	Rs.	5,000/-
h. Printing & Stationery	Rs.	5,000/-
i. Postage & Telegrams	Rs.	500/-
j. Ambulance	Rs.	10,000/-
k. Entertainment	Rs.	500/-
l. Leave Reserve	Rs.	5,000/-
m. Medical Books & Journals	Rs.	3,000/-
n. Maintenance of Building	Rs.	5,000/-
o. Staff Salaries*		

* Expenditure on account of staff salaries will depend on the staff strength and services offered at the health centre.

"Primary Health Care"

BY
MR. S. S. MOHSIN

In the International Conference on Primary Health Care, jointly organised by WHO and UNICEF in Alma Ata, U.S.S.R. in September, 1978, fundamental principles of health development were enunciated and a declaration was made. This declaration endorsed the earlier resolution of the 30th World Health Assembly (1977), that a minimum level of health for all the Citizens of the World would be attained by the year 2000 A.D., that would permit them to lead an economically productive and socially useful life. This is popularly known as Health for All (HFA) and it is to be achieved through primary Health Care Approach in a spirit of Social Justice and as a part of over all development. Development of Health is to be based on self-determination and self-reliance in health on the part of the individual, the community and the Nation. There should be more equitable distribution of health resources with preferential allocation of resources to those in greatest social needs. The health care system should adequately cover the population. The emphasis should be on preventive and promotive aspects, well integrated with curative and rehabilitative and environmental measures.

Concept of Primary Health Care

The Concept and dimension of Health Care and also those of health, were clearly defined at the International Conference, held at Alma Ata in 1978 Health Development should be considered as an integral part of Social and Economic Development.

Dimensions :

(1) Health is defined as a state of complete physical, mental and social well being and not merely an absence of disease or informity.

(2) Health also is a fundamental human right and therefore, the attainment of the highest level of health is a most important social goal.

(3) Achievement of health requires coordinated efforts of social and economic sectors, besides the health sector.

Characteristics :

Primary Health Care has the following characteristics :

(1) It is an essential health Care which is to be based on practical, Scientifically sound and socially accepted methods and technology,

National Institute of MentalHealth, Ranchi, Bihar, India

(2) It should be rendered universally accessible to the individuals and the families in the community through their full participation.

(3) Its availability should be at a cost, which the community and the country can afford to maintain at every stage of their developments in a spirit of self-reliance and self development.

Primary health care, an integral part of the country's health system should be a central function and the main agent for delivering health care. It is the first level of contact of the individuals, the family and the community with the national health system bringing health care nearer to the people.

Essential Components

For effective primary health care the following eight essential components are to be implemented in an integrated manner.

(1) Education of the people about the prevailing health problems and methods of preventing and controlling them.

(2) Promotion of Food Supply and proper Nutrition.

(3) Adequate supply of safe water and basic sanitation.

(4) Maternal and Child care and Family Planning.

(5) Immunisation against major infectious diseases.

(6) Prevention and Control of locally endemic diseases.

(7) Appropriate treatment of common diseases.

(8) Provision and supply of essential drugs.

Supportive Activities

For successful implementation of the essential components of primary health care, WHO has identified supportive activities which are :

(1) Community involvement and participation.

(2) Intra and inter sectoral co-ordination.

(3) Provision of effective referral support.

(4) Development and mobilization of resources.

(5) Involvement of managerial process.

(6) Medical and health Services research including innovative approaches.

(7) Development and application of appropriate technologies.

(8) Man power developments.

Operational Aspects

1. While about 78% of the population reside in rural areas about, 80% of medical

and health care facilities are located in Urban areas. Poor communication facilities and lack of transport for health personnel in rural areas add further to the problem.

2. Outreach and utilisation of Services in rural areas are limited. Health Services are not accessible in rural areas. A large percentage of deaths take place unattended by any qualified doctor.

3. Health education and awareness of its importance among the people is woefully meagre which results in under-utilisation of services. Illiteracy and superstitions cut across efforts to communicate with the community in health and related matters.

4. Integrated development is yet to take roots in our country.

5. Infrastructure development is still inadequate with low, doctor and health worker population, ratio some categories of health functionaries like MPW (Multipurpose workers), male and female are in short.

6. The per capita expenditure on health (medical and Public Health) during 1981-82 was hardly Rs. 28/- annually. Even then limited resources, made available to health Sector, are largely spent on Urban Curative services.

7. Plans are drawn up and implemented by health planners and programme administrators without the community being involved at any stage of the programme. The community never has the feeling that its participation is the most important component of the programme. As a result, there is lack of self-reliance on the part of the community.

8. In adequate and often inappropriate training of health personnel of all the categories coupled with lack of supportive and total absence of continuing education, have made the delivery system largely ineffective.

9. Lack of managerial skill among health professionals has contributed to poor health care services in the rural areas.

10. Many of the professionals who participate in the execution of Health programme have little appreciation of preventive and promotive aspects of health.

Need for Ma nagement Training and Continuing Education

Management has been defined as the purposeful and effective use of resources man-power, material and money (3 Ms) for fulfilling a predetermined objective. Managerial processes involve situational analysis :—Policy formulation, setting goals, objectives, targets framing of strategy, making plan of action, broad-programming, budgeting,

detailed programming, implementation-organisation of resources and initiation of activities, monitoring and control, evaluation and feed back, and programming.

Personnel of various categories working at different levels will need to apply different components of managerial process for strengthening health care delivery system. Functioning, at different levels would also require blending of varying degrees of managerial and technical skills. The higher is the level in the organisation, the greater is need for managerial function and lesser is the need for technical skills. Conversely, the lower the level in the organisation the lesser is the need for managerial functions and higher the need for application of technical skills. However, even, at the grass root level the development of well-coordinated and systematic style of functioning by various categories of personnel would be very important for proper management of the programme. Further more, in participating management the principles and different components of managerial processes should be well understood by all concerned.

With the object of developing management training programmes, the training needs of different categories of personnel have been systematically identified through adoption of four approaches. Following these approaches, managerial requirements and management problems at different levels were identified. On careful analysis certain management problems were found to be amendable to change through training, while others require specific policy decision and administrative actions, using the four approaches the main areas of managerial functions and the nature of activities reguired for fulfilling these functions were identified. The specific knowledge and skill required and the necessary attitude were defined. Based on these training carricula for strengthening the teaching-learning processes, these have been put into modula formates.

Continuing Education :

Continuing education provides the organisation and its workers with increasing efficiency to perform competently in their current and future jobs. It is the planned provisions for systematic learning in the job and is an essential element for personal and organisational development. An important factor for achieving Health For All (HFA) by 2000 A.D. would be the ability of the individual and the organisation to recognise and respond to changes in advancing technology for health maintenance and providing new pattern of diseases and disability, new social policy, expectation and programmes for better health services.

New competencies are to be developed at different levels to be able to observe, analyse, interpret, realistically and react intelligently to human behaviour, event and environments, and to effectively perform as a matter of the team, to address priority community-problems and concerns and to develop proper attitude for continuous

learning. The concept of life long education is being increasingly accepted as an indispensable suppliment to basic Education.

For maintaining high level of competence and performance and to strengthen national will to achieve H F A by 2000 A.D. through primary health care, development of adequate systems for continuing education and to integrate it with supervision at all levels would be most vital for proper health man power development.

Since continuing education provides the health personnel opportunities to learn new techniques, approaches, and attitudes for effective maintenance of standards of health care delivery and since it seems as an essential part of the process of introducing any changes in the method of health work, it is considered as an important part of the Management System or Management Process".

With Best Compliments

from

A WELL WISHER

Implementing People's Attitudes Towards Health Through Effective Information and Communication

BY

MRS. REEVA SOOD*

I take this opportunity to share with you our experiences at Asian Centre for Organised Research and Development (ACORD), of working with different communities to influence attitudes towards health through effective information and communication. Three experiences, about which I will share information with you were attained in a Delhi slum and in the rural areas of Uttar Pradesh, Madhya Pradesh and Rajasthan.

We realised, after visiting various communities that one of the major blocks in people's indifferent attitudes towards health issues was caused by lack of information on their part on various causes of ill-health and ways of preventing various common illnesses. We also realised that due to lack of exposure and education on their part, complicated messages in technical terminologies are not easy for them to understand. Here we saw a challenge for us. The challenge was to simplify the information and communicate it in a simple easy to understand ways to the people. Quite interestingly, this first called for education on our part. Meaning thereby that we had to first inform, acquaint and educate ourselves about the local stereo-type local language and local symbols through which people could understand what we have to share with them.

In one of our projects, we worked in the area of water - borne diseases. As we spoke to people, we realised that they did not relate any diseases with water. Several of them could not even distinguish one disease from the other. When asked about the prevelant disease, the most common respose was 'Bukhar' which means 'Fever'.

Some of you might be surprised to know that diarrhoea and dysentery, which is prevelant in 80% of the rural population is not even considered as an illness by most people. Similarly Jaundice is rarely recognised as an illness. There is some awareness about cholera and malaria but its source is not understood. Worms are considered to be developed by eating sweets. The cause of Jaundice wherever it is noticed is suppose to be the summer heat and typhoid is understood as the result of somebody eating food while having a common fever.

Wate is water. There is no question of its causing any disease is the belief.

Our first job was hence to develop materials by which they could easily understand that the contaminated water could cause diseases and even more important than that from even water is contaminated by people themselves. I will now take a few minutes to show some of the material that we have developed.

*Consultant, Asian Centre for Organisation Research and Development, New Delhi.

Apart from the flash cards, we developed songs, puppets, quizes, puzzles, stories, messages about the water-borne disease and ways of preventing them were communicated to the people by extension workers in small groups. Our follow-up gave us encouraging results and people had changed some of their habits and attitudes towards their own health. As you are aware, it has to be a continuous work to ensure that the new information and changed attitudes are sustained.

In some villages of Uttar Pradesh, though enough medical facilities were provided by an organisation, still we found that people were not availing such facilities voluntarily. The women would not step out of their houses for medical check-ups etc. the doctors would go from door to door for immunizing children and children would make a hue and cry on seeing the medical staff.

There was ignorance on the part of people about the need for immunization. Here too, we followed the same principle. Local women who are enthusiastic were given information about causes of infant diseases and mortality and educated on ways of preventing them through clean habits and immunization of great problem was complicated immunization schedule so we developed folk songs, often sung at child birth. The gist of the song based on a local folk tune was to save the daughter-in-law and children from diseases through immunization and their incorporating specific schedule in various stanzas of the song.

This apart from flash cards, etc. helped in changing people's attitude. Monitoring and follow-up in that area has indicated a clear impact seen in larger number of voluntary immunizations.

One of the major work, we call it 'Swayam Sidha' meaning self reliance, was initiated by our organisation (ACORD) in one of the urban slums in Delhi in September 1987. Though this urban slum with approximately 10000 population is situated right in the centre of the capital, neither any health or health educational facilities were in existence nor any awareness creating campaign had ever been launched by any voluntary or government agencies.

After talking to individual and people in small groups, informally and making visits to their homes, we found that health was a major problem. There had been high child mortality and morbidity due to tetanus, typhoid, polio and whooping cough and it was also noticed that no immunization programme had been carried out in the community on a regular basis.

People were not aware that majority of health problems could be prevented through immunization. Although there was a temptation to start immunization camps immediately,

it was decided that the initial approach could be made through health education. To impart message on health and hygiene, simple communication aids and materials were used in small groups time and again, feedback from the people was taken to ensure that the messages are understood correctly and adequately, people were encouraged to ask questions, raise issues etc. This resulted in lot of enthusiasm and interest and higher involvement of people. The usage of such materials also resulted in development of better rapport and voluntary action by people. Now people have gradually owned the responsibility of organising immunization camp. So here is a clear example of change in people's attitude through effective information sharing and education.

DISCUSSION :

Dr. Bhadkamkar, the Chairperson of the session summarised and gave his comments on all the papers. On the paper of Electronics in Primary Health Care (PHC) of Mr U.K. Bhatia, Department Electronics Govt. of India, New Delhi he appreciated the standard list of equipments provided for PHC. He doubted whether equipments like Wireless Set, X-ray Machines and Data Entry equipment can be used in rural community in the near future. However, he appreciated the R&D efforts of the Deptt. of Electronics. On the paper of Mr. D.K. Agrawal, he congratulated the Bureau of Indian Standards for their laudable work of standardisation. These norms if implemented in the Government Sector will cost a huge sum of financial inputs. The Chairman also agreed that all Hospital equipments must carry ISI mark as a mandatory regulation. On the paper of Dr. P.K. Verma, from University of Delhi he commented that 80,000 sq. ft. floor area is on higher side. The cost of construction is very high these days. However, the concepts were good. In the fourth paper presented by Mr. S.S. Mohsin on Primary Health Care (PHC) he appreciated the work paper on PHC. The Chairman remarked further on the paper of Mrs. Sood that was presented, to adopt health education, standardisation is difficult, therefore, local appropriate technology needs to be adopted. There should be decentralisation in terms of health education keeping in mind the local requirements. A very interesting discussion followed in which Dr. Rana from Shimla, Col. V. K. Singh from New Delhi, Dr. L.K. Singh from Manipur and Mrs. P. Ghei from New Delhi participated. The theme of discussions by these participants were more on constraint standardisation, planning of OPD and community health centre; 30 bedded hospital, paging system, etc. In the concluding remarks, the Chairman thanked the Speakers and the participants.

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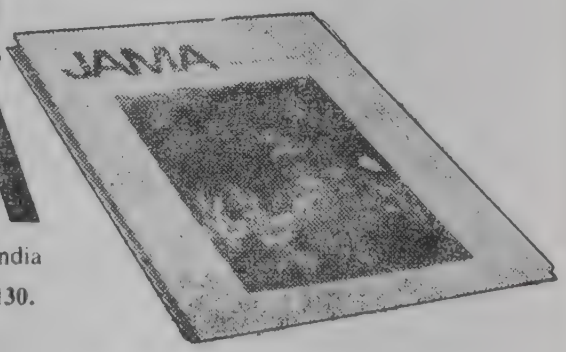

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August 23, 1988

The proceedings of the last day of the International Workshop on Hospital and Primary Health Care started with demonstration of Yoga Asans and exercises. These exercises bring in the concept of hollistic health. The demonstration was very much appreciated particularly by all participants from abroad and the idea that was developed in this Session was that the Indian Hospital Association should consider organising either national or international conferences on the role of yoga demonstration and yogic exercises in PHC as part of total Hollistic approach. The participants from abroad, KIFPH Fellows and others from abroad went for field visit to study PHC interventions in action in Urban areas. The Scientific Session, however, concurrently continued. The participants from abroad joined in the post-lunch sessions and activities.

The last day ended with a cultural performance depicting Indian dances and songs.

Demonstration of Yogasanas and Yogic Exercises
By the Students of

International Foundation of Natural Health and Yoga

August 23, 1988—Hotel Taj Mahal, New Delhi

Patron : Dr. P.N. Ghei, Secretary General, I.H.A.

Secretary General : Dr. Hira Lal

Secretary : Dr. N.S. Adhikari

EFFECT AND BENEFITS OF YOGASANAS AND YOGIC EXERCISE

1. Suryanamaskar (Salutation to the Sun)

i) It activates all endocrine glands and increases their secretions.

ii) It is excellent for getting rid of obesity.

iii) It makes the spine resilient, the waist slim and the body well-proportioned.

iv) It tones up the abdominal muscles.

v) It imparts great strength to the arms, hands, etc. and strengthens the entire body and also gives relief in arthritic conditions.

2. Paschimottanasana (Posterior-Stretch Posture)

i) Its practice ensures proper blood circulation to the entire body.

ii) It makes the spine resilient, waist supple and induces longevity.

iii) It is the best asana for curing skin diseases.

iv) It removes the odours of the body and generates a pleasant aroma.

v) It gives relief to patients of arthritis, sciatica and those who have pain in knees, thighs and legs.

vi) It makes the face radiant and gives repose to the mind also.

vii) It kills and eradicates the worms infesting the elimentary canal.

3. Bhujangasana (Cobra Posture)

i) It relieves constipation, indigestion and flatulence very quickly.

ii) It renders the waist supple, the chest broad and also reduces corpulence.

iii) It makes the body beautiful and well-proportioned.

iv) It is the first of a series of four asanas to be performed for cleaning the alimentary canal by the process of Conch-wash.

v) Patients of hernia are advised not to practice this posture.

4. Sarvangasana (All-Limb Posture)

i) It improves circulation of blood in general and blood from lower limbs returns effortlessly to the heart.

ii) It cures a number of skin disorders.

iii) It is excellent for reducing obesity.

iv) It makes the eyes radiant, face relaxed and the body beautiful.

v) It makes the spine resilient and the waist slim.

vi) It removes the bad odours from the body.

vii) It helps in treating the abnormal mobility of the uterus.

viii) Patients of high blood pressure should not practice this asana.

5. Dhanurasana (Bow Posture)

i) It makes the body supple and resilient, beautiful and radiant.

ii) It gives sparkle to the eyes and improves the eyesight.

iii) It is excellent for the vertebral column and makes the neck and shoulders strong and the waist slim.

iv) It improves the circulation of blood in the body.

v) It is highly useful for obese persons and for those with heavy buttocks and also for those who suffer from flatulence.

6. Kukkutasana (Cock Posture)

i) This asana makes the hands, the arms, the forearms and the elbows extremely strong.

ii) It drives away laziness, helps to carry on with little sleep and makes early rising easy.

iii) It makes the body firm and strengthens and broadens the chest.

7. Matsyendrasana (Matsyendra Posture)

i) It relieves the chronic enlargement of the spleen, flatulence and disorders of liver.

ii) It is the best asana for intestinal disorders and cures helminthiasis, the infestation of intestinal tract by worms.

iii) It provides immense benefit to patients of diabetes mellitus, besides eradicating many other diseases.

iv) It awakens the "serpent power" or Kundalni Shakti speedily.

8. Baddha-Padmasana (Bound-Lotus Posture)

i) It is very useful in ailments of the abdomen.

ii) It improves digestion rapidly.

iii) It cures many disorders of the uterus.

iv) It is highly useful for patients of hernia.

v) Its practice makes one immune to cold weather.

vi) It remedies the flabbiness and wrinkled condition of the abdomen after childbirth.

9. Yogasana (Yoga Posture)

i) It improves digestion and relieves constipation.

ii) It makes the body radiant and beautifies the features.

iii) It soothes and relaxes the mind and makes the body feel light.

iv) It cures respiratory ailments.

v) It replaces aggressive behaviour by gentleness.

vi) It brings down the fever quickly if a person with high fever brings his head into contact with the ground for 15 minutes in this asana.

10. Supt-Vajrasana (Lying Adamantine Posture)

i) It makes the waist resilient and the chest broad.

ii) It relieves fatigue quickly.

iii) It relieves painful conditions of the back and the knees.

iv) It is good for throat and tonsils.

v) It is helpful in restoration of the dislodged navel.

vi) It improves the circulation of blood and makes the body healthy.
vii) It can prevent Asthama if practiced from early childhood.

11 Akarna Dhanurasana (Pulled-Bow Posture)

i) It is particularly useful for the nadis which course obliquely and transversely from one side of the body to another.
ii) It improves circulation of blood in the nadis.
iii) It results in a supple and agile body.
iv) It makes the arms, forearms, shoulder, chest, waist, back, thighs and calves well developed, beautifully proportioned and strong.

12. Goraksbasana (Goraksha Posture)

i) It unifies the Prana and Apana and awakens the Kundalini.
ii) It is beneficial in cases of ano-rectal disorders and cures piles.
iii) It is excellent for the body below the waist, specially the joints and reduces the rigidity of the joints of the knee, ankle and pelvic region.
iv) Patients of urinary diseases must practice this asana.

13. Mrigasana (Deer Posture)

i) It makes the body light, feet nimble and improves the capacity to run and jump.
ii) It relieves the painful conditions of the hips and the knees.
iii) It makes the legs beautiful and well-proportioned.
iv) It makes the skin fine, lustrous, beautiful and radiant.

14. Mayurasna (Peacock Posture)

i) It relieves indigestion, constipation and flatulence very quickly.
ii) It relieves all the maladies of the abdomen.
iii) It is highly effective against disorders of the spleen and liver.
iv) It is extremely useful for persons with defective eye-sight.
v) It makes the hands, the arms and the elbows extremely strong.
vi) It is highly beneficial for the lungs.
vii) It can make a person immune to snake bites and scorpion bites if he practices it for 10-15 minutes at a stretch.

15. Padma-Mayurasana (Peacock and Lotus Posture)

i) It relieves flatulence.
ii) It destroys the bitterly poisonous elements in the diet.

iii) It strengthens the hands and the arms.
iv) It relieves disorders of the spleen and the liver.
v) It makes even the heavy food to prove wholesome.

16. Pranavasana (Pranava Posture)

i) It makes the spine supple and resilient.
ii) It makes a woman fail to conceive by inducing certain changes in the uterus.
iii) It helps in attaining concentration, which in turn leads to the stage of self-realization (Samadhi).
iv) It tranquilizes the mind and unifies the Pran and the Apan.
v) It relieves backache, piles and all other ano-rectal maladies.
vi) It develops the abdomen, the back, the shoulders and the neck.

17. Bakasana (Crane Posture)

i) It imparts great strength to arms and hands.
ii) It cures the ailments of the shoulder.
iii) It induces mental concentration.
iv) It helps in keeping the body balanced.
v) It increases the tolerance power towards many painful conditions.

18. Lolasana (Pendulum Posture)

i) It makes the upper limbs extraordinarily strong and develops the shoulders and the back.
ii) It helps the ribs to retain their resilience even in old age.
iii) It cures the trembling of the hands.
iv) It proves useful in cases of phosphaturia and other disorders connected with loss of minerals through the urinary passage.

19. Vrikshasana (Tree Posture)

i) It imparts great strength to the upper limbs.
ii) It improves the blood circulation and enables all vital organs to get sufficient quantity of blood without any effort.
iii) It is excellent for patients of Asthma.
iv) It cures many skin disorders.
v) It helps in attaining celibacy and sublimates the sex drives.
vi) It should not be performed by patients of high blood pressure and those who suffer from heart diseases.

20. Garudasana (Eagle Posture)

i) It strengthens the feet and the thighs.
ii) It is highly beneficial in cases of enlargement of the testicles.

iii) Its practice quickly relieves fatigue.
iv) It cures arthritic disorders of the knees, the feet and other joints and pain of the shoulders, the elbows, the arms and the forearms.
v) It is also useful in cases of ano-rectal and urinary maladies.

21. Padangushthasana (Big-Toe Posture)

i) It makes nocturnal dreams disappear and helps in attainment of celibacy. It also rectifies the seminal disorders.
ii) It quickly induces concentration of the mind and stability of the body.
iii) It develops self-control and full sex potency and virility.
iv) Its practice leads a person to have a healthy body and a mind full of vigour.

22. Sirshasana (Head-Stand Posture)

i) It is highly effective in curing diseases and cures most of these.
ii) It instils vigour into and revitalises the skin and prevents the falling and greying of hair.
iii) It directs the flow of the blood to the upper portions of the body and keeps the heart toned up.
iv) It sublimates the sex energies and rids the semen of impurities.
v) It makes the face radiant and relaxed and the eyes sparkle.
vi) It helps in curing a number of mental diseases.

23. Takiasana (Pillow Posture)

i) It unifies the Pran and the Apan and arouses the Serpent Power.
ii) It is highly effective in changing the nostril through which breathing takes place.
iii) It is effective for the eradication of many physical ailments.
iv) It generates subtle powers.

24. Gomukhasana (Cow-Head Posture)

i) Its practice gives strength to the feet, the knees and the waist.
ii) It develops the arms and the shoulders.
iii) It is very helpful in diseases of the lungs.
iv) It enables a person to inhale greater amounts of oxygen than is ordinarily needed.

25. Simhasana (Lion Posture)

i) It relieves the ailments of the oral cavity, the teeth, the tongue, the jaws and throat.
ii) It helps in attaining celibacy and generates fearlessness.
iii) It makes the voice clear and improves the eyesight.

iv) It helps in developing power and virility and makes the person more self-controlled and disciplined.

v) Its practice involves the application of all the three locks, i.e., the Basal Lock (Mula Bandha), Abdominal Lock (Uddiyan Bandha) and the Chin Lock (Jalandhara Bandha) and as such the powers attributed to all these locks are attained.

26. Tribandhasana (Triple-Lock Posture)

i) It relieves many of the ailments of the abdomen, stimulates digestive functions and also relieves constipation and flatulence.

ii) It is helpful in the treatment of all ailments of spleen and liver.

iii) It cures even deep-seated fevers.

iv) In this asana, asana (posture), mudra (pose) and pranayama (breath regulation) are performed simultaneously.

27. Urdhva-Hastottanasana (Up-Stretched Arms Posture)

i) It makes the waist slim and the chest broad.

ii) It increases height and relieves painful condition of the ribs.

iii) It is one of the four asanas (postures) used in the cleaning of the alimentary canal by the process of Shankha Prakshalana (conch-cleansing).

iv) It relieves constiption very easily and quickly.

28. Konasana (Angle Posture)

i) It relieves backache and develops the buttocks, besides making the body light and well-proportioned.

ii) It cures the ailments of the lungs and helps in increasing height.

iii) It cures the pimples on the skin and is also useful in sciatica.

iv) It helps in increasing height.

v) It harmonises and equilibrates the various nerves which course transversely and obliquely through the body.

29. Kati-Chakrasana (Lumbar-wheel Posture)

i) It makes the waist slim and supple, and expands the chest.

ii) It relieves constipation quickly.

iii) It prevents many respiratory ailments by making ribs resilient.

iv) It strengthens the shoulders, the neck, the arms, the abdomen, the back and the thighs.

v) It is one of the four asanas used in Conch-cleansing.

30. Nauli Exercise

i) It helps in achieving control on pressure dynamics of abdomen.

ii) It increases the circulation of blood by rotation of the recti.

iii) It activates the nerve plexuses and their terminals and induces a better coordination between their autonomic functions.

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iv] It produces a negative pressure in the abdomen and hence sucks up more blood and also ejects the wastes faster.

v] It provides a massage of all the abdominal viscerae.

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   (ii) That Natural and Yogic healthy living is best insurance against sickness.
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3. To give Theoretical & Practical Education on Yoga/Naturopathy.
4. To propagate the message of Natural Health and Yoga to every home and individual the preventive aspects of Natural Hygiene.
5. To foster and to conduct research in the Science of Natural Hygiene and to publicise the results thereof through the media.
6. To establish, maintain and subsidise Natural Health Homes, Libraries, Yogic and physical culture centres, Sports Clubs, Holiday Resorts of Natural Hygiene and Yoga, Health Food Stores and such other things which contribute to healthy living.
7. To help the society in attaining Physical, Mental and Spiritual balance and Economical and Social well-being, with special emphasis on women, children, aged, disabled and weaker sections.
8. To educate the people regarding the destructive effects of denaturing food in the name of refining, preseriving or bottling, involving the use of inorganic and poisonous chemicals and dyes.
9. To give financial and other aids to other charitable institutions carrying on work in the field of Natural Health and Healing.
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11. To do other acts as are incidental to or helpful in the attainment of the above aims and objectives.

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March 1989

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23-8-88

Scientific Session IV

CHAIRPERSON

Dr. S.S. Rikhy
Patron,
International Workshop on Hospital and Primary Health Care and
Life Member of IHA, New Delhi (India)

SPEAKERS

(1) Pre-testing WHO PHC Manual - A Report
Dr. (Mrs) K. Kathpalia,
Formerly Incharge, Manual Cell of Directorate General of Health Services,
Ministry of Health and F.W.
Government of India (India)

(2) Hospital - PHC Initiatives - Role Model
Col. B.M. Sakharkar
Armed Forces Medical Services
Commanding Officer
Military Hospital
Ahmednagar (India)

(3) Relevance of Radiation Sterilization in Primary Health Care (PHC)
Mr. R.K. Sharma,
ISOMED
Bhabha Atomic Research Centre,
Bombay (India)

(4) Patient Transport in Urban Health Community (UHC) in Emergency
Prof. N.P. Singh
Professor and Head of Department of Anaesthesia,
Lady Hardinge Medical College & Hospital, New Delhi (India)

Pretesting WHO PHC Manual—A Report*

The project of Pre-testing of WHO Manual for Trainers of Primary Health Workers in collection of Health Information was assigned to Rural Health Division of the Ministry of Health and F.W., Government of India, New Delhi in 1986. This was carried out as Multi-centric study and the officers involved were Dr. M. D. Sehgal, Dr. (Mrs) Tripta Bhasin, Dr.(Ms.) A. Bhardwaj, Dr. (Mrs) K. Kathpalia and Dr. P.N. Ghei. The paper based on this study was presented on 23rd August, 1988 during the International Workshop on Hospital and Primary Health Care, New Delhi.

INTRODUCTION

The WHO Member States in adopting the policy of "Health For All by 2000" have expressed their will to mobilise all human resources, in particular all types of health personnel, to provide their populations with atleast essential health care services.

Primary Health Care Workers play a key role in the Information Support System. To plan and evaluate health care programmes, relevant information must be collected by primary health care worker from each of the activities being performed by him or her. He or She must therefore be trained in collection of the health related information and using the same for improving the health of the community. Accordingly a Manual containing guidelines on Training Trainers of Primary Health Care workers in the collection and use of health related information was prepared by a Working Group in Geneva in December, 1982. This Manual was required to be field tested and India was one of the countries selected for the field testing.

This Manual, in addition to guidelines, also identified:

(a) Eight areas of essential primary health care.

(b) Tasks required of health workers for each of the eight primary health care elements;

(c) The skills needed by Primary Health Worker (PHW) to collect and use information; and

(d) Knowledge, skills and attitudes needed by primary health worker trainers.

**Presented by Dr. Mrs. K. Kathpalia.*

The manual of guidelines was divided into 4 main parts. The scope and coverage of each part is as follows:

Part I	:	Motivating the Health Worker to collect and use Health information.
Part II	:	Keeping records, and some examples of sample record forms.
Part III	:	Collecting and recording health information.
Part IV	:	Analysing and using health information.

These guidelines assumed that PHW can read and write and know simple arithmetic.

WHO entrusted Rural Health Division of the Ministry of Health and family welfare to carry out field testing of the guidelines on Training Trainers (Supervisor) of PHW in the collection and use of health related information. The Officers of the division concerned with the study devised Multi-Centric approach in which following 5 centres participated :

1. Health and Family Welfare Training Centre, Agra, Uttar Pradesh.
2. Health and Family Welfare Training Centre, Ajmer, Rajasthan.
3. Health and Family Welfare Training Centre, Ahmedabad, Gujarat.
4. Gandhigram Institute of Rural Health and Family Welfare Trust, Madurai Tamil Nadu.
5. Health and Family Welfare Training Centre, Jabalpur, Madhya Pradesh.

Methodology

A meeting was held in the Ministry in which all the five Training Centres participated.

Keeping in view the requirements of the project a work plan was decided upon and following objectives were laid down :

(a) To determine whether the learning objectives of the guidelines are relevant to the tasks to be performed by the PHW in collection and use of the health related information.

(b) To determine the extent of gain in the knowledge and skills of PHW in the collection and use of health related information.

(c) To determine the adequacy of the contents in imparting necessary knowledge and skills for performing his tasks related to collection and use of health related information.

(d) To determine the usefulness of training methodology given in the guidelines in improving the skills and knowledge in the collection and use of health related information.

(e) To evaluate improvement in the knowledge, skill and attitude of Primary Health Worker in the collection and use of health related information and their field performance after training.

It was further decided that :

(i) Health Worker (male and female) will be considered as Primary Health Worker.

(ii) Faculty of Health and Family Welfare Training Centres will be treated as trainers of Primary Health Worker who will be imparted training by the Principal of the Training Centre for 30 hrs.

(iii) Each Training Centre will include in the study of 10 Sub-Centres comprising of 20 Health Workers (10 Male and 10 Female).

(iv) The Health Workers will be trained for 90 hrs.

(v) In order to have a uniform pattern of reporting in all the 5 centres, the health worker (male and female) after the training will be asked to fill-up proforma from the Manual of Health Worker Female issued by the Ministry of Health and Family Welfare because this forms a part of National information System. However, the proforma will be translated in the regional languages by the training centres.

(vi) Due care will be taken to cover all the four parts of the guidelines.

Summary of the Activities Undertaken by the Training Centers.

The activity commenced in March, 1986 and the final reports were submitted by the training centres in December, 1986.Each training centre organised the following activities ;

1. Conducted training for the faculty members who were trainers in the project.
2. One primary health centre was selected for the activity and 10 sub-centres of this primary health centre were chosen for the study.
3. Both male and female health workers of the sub-centres were given training.
4. Training period for trainers (supervisors) ranged from 30-38 hours and for the Health Workers from 68-90 hours.
5. With the help of State and district authorities selected PHCs and sub-centres were adequately stocked with the required drugs, vaccines, slides and other equipment such as weighing machines diaries, registers and report schedules, etc.
6. Supervision of the Primary health workers in the field was carried out by the fortnightly/monthly visits by the faculty of training centres.
7. Evaluation performance was filled in and
8. Final report submitted by the training centre.

By large the training centres adhered to the guidelines except for minor variations which can be seen from the comparative statement.

On the basis of the reports received from the Training Centres, Draft Guidelines sent by WHO were modified and final report forwarded to WHO in May, 1987. The major modifications were addition of

(a) flow chart on M.I.E.S. of the Ministry of Health and F.W.

(b) a sociogram

(c) addition of examples of local prevalent situation in the field.

(d) pictorial demonstrations.

Discussions :

From the reports received from the training centres it was observed that although clear cut guidelines were given to all the training centres and there was frequent monitoring of the training activities by having meetings in the Ministry still there was a difference in approach to the problem. Further, the comparative statement also shows that the number of trainers differed in all the 5 situations, the training given to the trainers also differed and even the time spent in training varied from Centre to Centre.

The partwise discussion revealed that the Part I was very easy, simple and interesting, more time was required for Part III and reinforcement was done for Part II and IV.

Constraints :

The constraints felt by each training centre vary, however, the common constraints felt by all the training centres were :—

1. There were frequent changes and transfers of the Primary Health Workers.
2. Due to priority of certain National Programmes like Family Planning and Nutrition, the worker could not devote adequate time to collection of the information and
3. Selection of the Health Workers and their trainers had to be done according to the rules in each state.

CONCLUSIONS :

(a) The study indicated that the objectives were achieved to a large extent, that is,

(i) There was an appreciable gain in the knowledge and skills of PHW in the collection and use of health related information.

(ii) the learning objectives of the guidelines were very relevant to the tasks being performed by the health workers Male and Female in the context of Primary Health Care activities in India.

(iii) the training methodology was useful; however, alternative approaches which had to be adopted due to local situation proved equally successful.

(iv) Contents of the Manual were adequate, however, additions were made to make it more meaningful and relevant to the local field situation faced by our workers.

(v) The training was very much appreciated by the PHW. It was for the first time that the information collected by the healthworker was actually used by the worker for improving his or her work. They were thus convinced for the need of collection of proper health data. There was a very good response from the community and when meetings were held with them as they realised their own role in the improvement of the health status of their own village.

(b) Office of the WHO has also conveyed their appreciation of the field testing of the guidelines and has expressed their keenness to extend the study to develop training modules to support the activities related to the Information support to HFA.

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Hospital-PHC Initiatives : A Role Model

BY

COL. B. M. SAKHARKAR*

INTRODUCTION

Having realised that the content of primary health care at a hospital (hospital based PHC) is not different from PHC elsewhere, health care administrators are realising that effective hospital involvement in PHC requires a much broader vision and a wider range of action rather than the hospital's typical concern for the cure and care of individual patients. The connotation in the minds of the people that PHC is primitive care for the rural poor has been overcome gradually over the past one decade since it's inception. That PHC can also be delivered at and by hospitals at a somewhat higher level of competence was also subsequently realised. Even then, the traditional hospital disinterest in PHC is hard to overcome.

As part of the overall health care system in the country, Military Hospitals would appear to be no exception to this. However, military hospitals have been involved in PHC in many ways even before PHC became a popular word after the Alma Ata declaration of 1978.

A military hospital is not primarily designed for PHC yet it plays that role and gives maximum support to all phases of health care including primary health care in a military station. This paper outlines the salient features of the approach to health care including PHC by military hospitals and the shifts in emphasis and the organisation that permit an efficient delivery of PHC activities.

Although the role description is that of a general hospital with about 200 beds and a fairly defined catchment area it is applicable to all other hospitals, the difference being that of scale only.

Historical

Evolution of the concept of positive health was the outcome of historically evolved military requirements of armed forces personnel. To overcome the large scale preventable morbidity, the concept of total health care evolved because of the requirements of every military station as a whole when the country was facing repeated epidemics, large endemic areas of preventable diseases, no assured safe drinking water supply and poor to non-existent waste disposal.

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Inspite of their apparent isolation from the mainstream health systems, it will be no exaggeration to say that military hospitals have been pioneers in the medical care field, setting examples for the post-world-war emergence of other hospitals in India. But, the concept of 'positive health' and 'total health care' that are integral to military medicine seem to have been lost to the modern hospital in the civil sector.

Hospital-PHC Initiatives : Coordination the Vital Ingredient

The eight elements of PHC, as we now understand them, viz [1] adequate nutrition, [2] safe and adequate water supply, [3] safe waste disposal, [4] maternal and child health and family planning ; services, [5] prevention and control of locally endemic diseases, [6] diagnosis and treatment of diseases and injuries, [7] provision of adequate drugs and supplies, and [8] health education, have always been a part of the total health care system in all military stations.

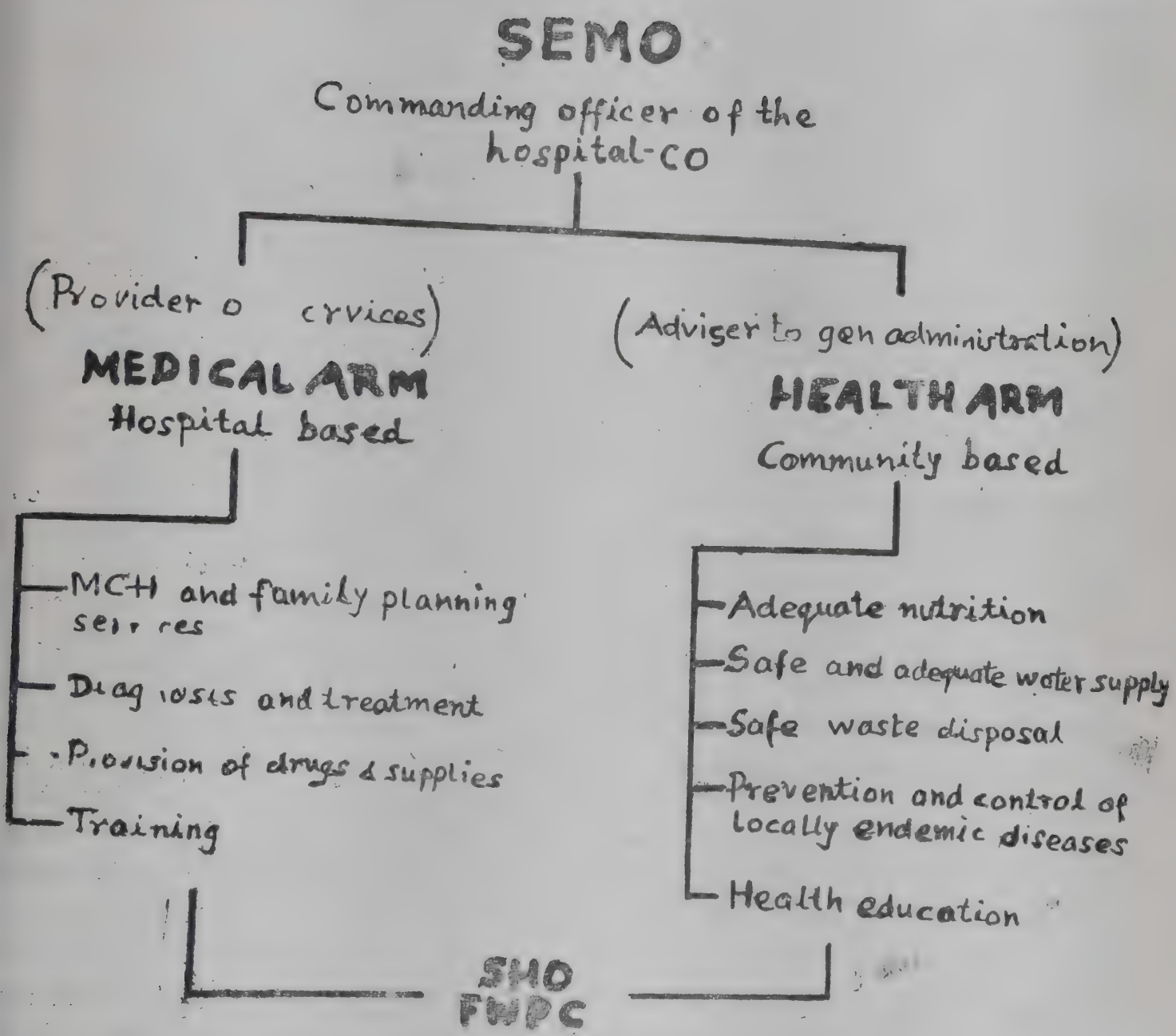
With such diverse elements, some of which are outside the control of health professionals, the most crucial factor in the management of hospital-PHC initiatives is *coordination.* An important reason for unsatisfactory progress in this field at many places is the difficulty in inter-sectoral coordination at planning as well as execution level. It is this aspect that has been effectively taken care of by creating in one person the coordinating function in each military station. And this person is none other than the chief executive or the Commanding Officer [CO] of the local hospital. The CO is designated as the Senior Executive Medical Officer [SEMO] and is responsible for the health and well being of the entire population in the station. As SEMO, his responsibility is to act as adviser to the senior most administrative commander at the local level on all matters related to health, including housing, water supply, sanitation and waste disposal. The organisational arrangements to bring about the desired outcomes is depicted in the diagram overleaf—

This organisational arrangement meets the coordination requirements very effectively and is described below.

Health Related Role

Safe and adequate water supply, safe waste disposal—All these facilities are comparatively better in military stations. In no small measures this is brought about through the role of the SEMO in all 'civic' matters. Being adviser to the general administrator in all matters related to health, his advice is brought to bear upon the executive agencies in housing, water supply, sanitation and waste disposal in the station. This is a unique system of health administration dovetailing into general administration through a medical professional directly related to the hospital.

Prevention and control of locally endemic diseases—Activities related to the prevention and control of locally endemic diseases are channeled through another arm of



This organisational arrangement meets the coordination requirements very effectively and is described below.

the SEMO, called the Station Health Organisation (SHO), with one of the doctors from he hospital functioning as it's officer in charge, and which has a staff of a health superintendent, two health assistants, a laboratory assistant [all trained in public health work], and a storekeeper and some unskilled labour. Only in very large stations does SHO have a full-fledged officer in charge and he is then a specialist in preventive and ocial medicine. Monitoring of food handling establishments, general sanitation, rainage, sewage, water supply and environment are the main concerns of the SHO on

behalf of SEMO. The activities it carries out are mass surveys, investigation of outbreaks, and vector control.

Health Education. The state of health of troops, their families and children justifies the very high importance placed on preventive medicine in military stations. Helping others learn to care for themselves encourages self reliance and equality. The FWPC (described later) and SHO are also made responsible to carry out health education. The most effective health education is given when a person must feels the need for it, that is, when he is sick. But health education is most needed when the person has no apparent need for it. Community visits by the family welfare extension educator and lady health visitor of FWPC present appropriate opportunities for the task, besides the opportunity to talk to the mothers and pregnant women while they visit FWPC for various services. Each SHO has also developed a 'demonstration area' and museum for this purpose, where troops in station are taken on 'conducted tours' by the health staff. Health education by the SHO is related to water supply, waste disposal and prevention of communicable diseases.

Training. In the armed forces the role of self-help through first-aid of common ailments, injuries and emergencies is a well recognised measure in saving lives and limbs and minimising complications. Self help through first-aid is also one of the components of PHC. To this end organising training cadres for troops in first aid is enjoined upon the RMOs. With a general awakening in the female population, some SEMOs have started such training for girls and housewives.

Selected personnel from each unit are sent through a short course of training in health, hygiene, sanitation and water duties at the SHO, and refresher courses thereafter, back in their own unit environment, the monitoring and execution of all health measures at the local level is entrusted to them under the supervision of their respective regimental medical officers.

MCH and Medical Care Related Role

MCH and family planning services. Mothers are central to their children's health but are generally passive recipients of medical aid. Military hospitals play a significant role in the mothers' involvement in their own health and their childrens'. It has been advocated that although a consistent relationship should be developed between the hospital and the community, the hospital should not make attempt to dominate any peripheral programme and make it dependant on the hospital.[1] This is partially soughtt o be achieved through a semi formal institution called the Family Welfare Centre (FWC) in each unit community, where facilities for pursuing crafts such as knitting, embroidery, sewing, toy making, etc are made available. They act as incentives for the women to visit and where the services of a lady doctor are provided on fixed days in the week at the unit's own initiative. Some centres have employed a nurse on permanent basis.

The linkage with the hospital is maintained via the Family Welfare Planning Centre (FWPC) based at the hospital with a staff of family welfare extension educator (WFEE), a lady health visitor (LHV) and attendant. Provision of all family planning services and immunisation services are the two main functions of this hospital based centre, achieved by integrating MCH with family planning programme into a package of activities, including—

1. distribution of contraceptives
2. I.U.D. insertions
3. MTP
4. Sterilisations
5. Motivation.

The FWEE and LHV undertake regular visits to all units in the station for meeting people in groups for motivating them and for health educations, the LHV also visiting expectant and lactating mothers individually at their homes.

Of all the health services, immunisation is the most simple and cost effective and FWPCs have been able to achieve extremely good coverage. Against only 33% of urban children below two years immunised with BCG, 24% against DPT and 11% against polio in the general population in India[2], we have been able to achieve very good coverage of 85. 7%, 79.7% and 70.9% respectively as revealed in a recent survey[3]. As opposed to 29% of infant deaths and 22% of child deaths in urban areas occuring without receiving any trained medical attention, it's availability and accessibility through peripheral clinics has brought this down to zero.

Provision of diagnostic and treatment services. One important aspect of PHC is the provisioning of medical care services based within the community for diagnosis and treatment of common diseases and injuries, with the support and back-up of the diagnostic and treatment services of the hospital when needed. This can be achieved either by establishing in the community independent peripheral health centres or by satellite clinics of the hospital. In military stations this is met through medical posts alloted for a unit with a defined population. The post is called Medical Inspection Room (MI Room - this name still continues as a legacy of the post), sick Bay or Station Sick Quarter. The post is manned by a medical officer with a few paramedical staff and is responsible also for providing preventive and promotive services in the community in addition to medical care. Population in the vicinity of the hospital and that which is not covered by other MI Rooms is looked after by the hospital MI Room which has a similar organisation as other MI Rooms. At MI Rooms the community gets medical care that is locally available and with high accessibility.

The diagnosis and treatment services at the MI Rooms are strengthened and supported these services based at the hospital. The hospital laboratory and x-ray department carry

out investigations ordered by the doctors of the MI Rooms and the results are directly sent to them. Patients referred by them to various specialists for opinion or further management are attended by the specialists at their respective OPDs and those requiring indoor treatment are admitted to the hospitals. An important thing to note here is that the cases referred to specialists are returned back by them to their own MI Rooms for further continuation of treatment and management, thus fulfilling the concept of two-way referral. So are the cases after discharge from the hospital.

Provision of adequate drugs, supplies and logistics support. The total responsibility in respect of all dependant MI Rooms in this regard devolves on the hospital. In respect of the consummables the indents of the MI Rooms are met at agreed intervals, usually fortnightly or monthly and based on a previously worked out monthly maintenance figure (MMF). It is also the hospital's responsibility to arrange for replacement of the condemned and unserviceable items of equipment. The hospital also undertakes to supply sterile syringes and needles through it's CSSD. Ambulance service of the hospital has been made available to all MI Rooms on call for transporting lying cases requiring hospital admission.

Summary

Delivery of medical care including primary health care through the agency of the hospital, and prevention and control of endemic diseases through public health measures are the two facets of the work of a CO of a military hospital. The philosophy of hospital policy for health, including PHC, that has evolved centrally has to be expressed and implemented through specific plans of action by individual hospitals. These plans of action have been put into practice at the hospital level in the form of—

1. Active involvement in public health functions by advising local commanders, monitoring health conditions, supervising public health measures and providing health education.
2. Provision of admission and specialist treatment facilities.
3. Establishment of a two-way referral system from MI Rooms to hospital and in the reverse direction.
4. Provision of technical support in the form of pathology and rediology services for early diagnosis and better management at MI Rooms.
5. Maintaining logistics support through supply of drugs, dressings, supplies and equipment, and provision of ambulance services.
6. Providing training to non technical personnel in hygiene, sanitation, water duties and first aid.

Epilogue

Early diagnosis and detection, early intervention, health education and prevention are basic to PHC, but most hospitals view their role mainly as deliverers of curative services. Most patients need primary medical care rather than secondary care but because of the lure of the hospital or because of the feeling that effective diagnosis, treatment and drugs can only be found at the hospital, tend to by-pass or ignore the first contact services.

A built-in structure of primary health care programme within the hospital organisation is very much essential to stimulate dynamic interaction between the different interests of disciplines in the hospital. A slow and difficult process of motivation of specialists, because of the existing medical training system, needs to be undertaken to get them interested and participate in the PHC programme also Too few hospital professionals are trained and inclined to think in the community-wide context. A substantial fattitudinal change requires to be brought about if the centrality of PHC is to be accepted as the basis of hospital involvement.

If PHC has to become the central function and main focus of the health system as envisaged in the Alma Ata Declaration 1978, hospitals as the most visible part of the health system have a great responsibility in making it so.

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Relevance of Radiation Sterilization in Primary Health Care (PHC)

BY
MR. R.K. SHARMA *

1. INTRODUCTION

The need for using disposable medical products is greater now, than ever before. There is sudden spurt globally, in the use of disposable sterile gloves and disposable sterile gloves sterile syringes, possibly to check the spread of AIDS and other similar diseases. One of the industrial processes for sterilization of disposable medical products is radiation sterilization.

The concept of radiation is familiar to all of us. We get exposed to cosmic radiation; radiation from radioactive materials like potassium-40, tritium, present in our bodies; radiation from naturally occurring radioactive materials present in earth (Fig. 1. on page 170). All these contribute to "background" radiation. We get radiation exposure from man-made sources like X-ray machines and colour television. Normally the cumulative exposure is within the limits of safety.

Most of us know about the isotopes. These are the atoms having different weights but belonging to same chemical element. For example, radioactive cobalt-60 is produced by neutron activation of naturally occurring cobalt-59. In simple terms it means, one neutron is added to the nucleus of cobalt-59, in a nuclear-59, in a nuclear reactor—thus making it cobalt-60.

The process of emission of radiation from unstable atoms is called radioactivity. Some of the isotopes emit gamma radiation, which is a type of electro-magnetic radiation, with extremely short wave length. It is one of the powerful sterilants and exerts antibacterial action by damaging DNA. Cobalt-60 and caesium-137 are the common sources of gamma radiation. The energy levels are high enough to penetrate robust packaging materials like polyethylene bags or aluminium collapsible tubes. It provides terminal sterilization of the contents. However, products sterilized by gamma radiation *do not* become radioactive.

The process of radiation sterilization involves products packed in hermetically sealed packs and then exposure to gamma radiation for a predetermined time—so as to deliver a minimum dose of 25 kilo Gray. In cases, where pre-sterilization bacterial count is not

**ISOMED Bhabha Atomic Research Centre, Bombay (India)*

known, the dose of 25 kilo Gray is internationally accepted as the sterilizing dose. The time required to deliver the dose is inversely proportional to the strength of Cobalt-60 source. At ISOMED, it takes about 20 hours to deliver the minimum dose of 25 kilo Gray since the source strength is about 16.1 X 10^{15} becqurel or 435 kilo curies. Becqurel is a unit of measurement of radioactivity & it means one disintegration per second. It would take half the time to deliver same does, if we double the source strength.

We have the option to adopt a sterilization process, among a number of them. A comparison of dry heat, autoclaving, ethylene oxide, formaldehyde and radiation sterilization (Table 1, on page 172) shows that a number of process parameters, namely, temperature, pressure, vacuum, humidity, post-sterilization drying or degasing and time are involved. Radiation sterilization requires control of only one process parameter-time unlike others where 4 to 5 parameters have to be monitored. This makes radiation sterilization, less prone to operational errors.

The other factors, which influence, are product density, choice of packaging and the conditions (Table 2, on page 172). While product density is common for all the methods, choice of packaging is wide in case of radiation sterilization. One can choose robust packaging, to withstand longer shelf life.

A look at the characteristics of the sterilization processes (Table 3, on page 173), shows that radiation sterilization alone can be a continuous process. Mode of antibacterial action in case of dry heat is by denaturation of proteins, in case of autoclaving, by coagulation of proteins, in case of ethylene oxide, by alkylation. The blockage of reproductive functional groups of the cell, by ethylene oxide, thus impairing the cell's reproductive capability, is termed alkylation (Fig. 2 on page 171). Radiation exerts bactericidal action by damaging the DNA. Sterilization in the final shipper pack is possible only in case of radiation sterilization. Thus there can be no operation contamination, once the product has been radio-sterilized.

Let me introduce the term inactivation factor (Annex 1, on page 171), which is the ratio of pre-sterilization count to the post sterilization count. If initial contamination of an organism is 10 and I.F. = 10^6, then safety factor is $10^6 / 10 = 10^5$. It means, if hundred thousand articles are tested after a dose of 25 kilo Gray, the probability of survivor will be only one. Hence higher the inactivation factor, higher would be the safety factor. For I.F. = 10^6, we can express log of inactivation factor as 6.

Log of inactivation factor is 15 to 20, in case of autoclaving, 8 to 9 in case of ethylene oxide and 9 to 860 for gamma radiation (Table 4, on page 173). Another major aspect is residual toxicity. Only two processes, namely ethylene oxide and formaldehyde can lend toxicity to the products sterilized, using these methods. Ethylene oxide and it's reaction product, ethylene chlorohydrin are base pair mutagens and potential carcinogens. Hence

it is important, these toxic substances are present within the limits defined by Federal Register of U.S.A. or I.S.I.

A quick look at the log of inactivation factors for some of the microorganisms, for a radiation dose of 25 kilo Gray shows, (Table 5, on page 174) gram +ve microorganisms like *staph. aureus*, *C. acnes*, *D. pneumoniae*, *S. lutea*, have log I.F. in the range 139 to 28. Gram -ve (Table 6, on page 174) like *Ps. aeruginosa*, *E. coli*, *S. Paratypht B.*, *K. pneumoniae*, *A. aerogenes* are in the range 860 to 45. Spore forming acrobes (Table 7, on page 174) like *B. globigii*, *B. subtilis*, *B. sterothermophilus* & *B. pumilus* range between 21 to 8. Spore forming anaerobes (Table 8,on page 175) like *clostidium botulium*, *sprogenes*, *tetnai* & *welchii* range between 19 to 7. In one of the reported studies (Annex 2, on page 171), there was complete destruction of yeast & yeast like fungi and molds and molds like fungi, below a dose of 10 kilo Gray.

As a part of our quality assurance program, we use the microbiological challenge strips of *Bacillus punilus* and after irradiation, test them for sterility. It is advisable to periodically challenge the method of sterilization, using the appropriate challenge microorganism (Table 9, on page 175).

We employ dosimeters to ascertain the dose delivered to the products and certify the minimum dose given. The radiation indicator button, which is yellow originally, turns red on irradiation. It is a proof of the sterilization method used. It does not reflect the sterility status.

A look at the environment of primary health care centres which are normally located in distant parts of the country, shows inadequacy of intra-hospital infrastructure like instruments, their maintenance etc. They leave a lot to be desired. The extra-hospital infrastructure like power at proper voltage, is inadequate. Thus efficient management of in-house sterilization facility on a long term basis, becomes difficult.

Some of the cause and sources of nosocomial infection are, inadequacy of sterilization process in terms of inactivation factor, presterilization count and the caliber of operating personnel. Two, hazards of instrumentation, like catheterization, the use of wound suction units, etc. Third, cross infection due to overcrowding of patients and a large number of visitors and four, decrease host resistance due to malnourishment.

Infection control through quality assurance in hospital management is possible through orchestration of administration, medical staff, nursing services, laundry & linen, dietary, house keeping, engineering and maintenance.

In this background, if sterile disposable products are available on the shelf, it would facilitate normal surgical procedures and emergency operations can possibly be carried out

on time—thus saving precious human lives. It can also cut down the incidence of nosocomial infection.

Some of the major items which can cater to the needs of the P.H.Cs can be the following sterile disposable kits:

- minor surgery kits,
- vasectomy kits,
- tubectomy kits,
- mid-wife's (Dai's) kits,
- eye-camp surgery kits.

These kits may contain the required amount and size of items like gauze, cotton, suture, disposable scalpel etc. all packed in double polyethylene bags. At the time of use, the bags can be cut open and sterile contents used for the patient. The irradiated products remain sterile for an indefinite period, provided the packing remains undamaged. The other disposable products of use in P.H C.s, that are routinely being radiation sterilized at ISOMED, are infusion sets, blood donor sets, blood collection sets, scalp vein sets, catheters.

Gauze, cotton etc. can be individually packed in unit packing. When autoclaved, the sterility, of remaining contents is subject to question, when the drum is opened to draw the initial lot.

The other radiation steri'ized products are, surgical gloves, wound suction units, sutures, surgical blades, orthopedic implants, babies' nappies.

It is not practical to steriline routine surgical instruments, linens, endoscope sand water-based solutions by gamma radiation.

In our country, where economic considerations weigh heavily, cost becomes an important parametar. To give an idea about the cost, D.H S., Maharashtra procured radiation sterilized mid-wife's kits from the market. Each kit contained gaze, cotton, thread, razor blade and an instruction sheet—all packed in polyethylene bag. The kit was priced at about Rs 3/- each. The sterilization charge per kit was about 5 paise only.

6. CONCLUSION :

Radiation sterilized products can certainly provide an answer to the needs of P.H.Cs—to a reasonable extent. It is practical to use them, they are economical and need be tried out.

RADIATION
A FACT OF LIFE

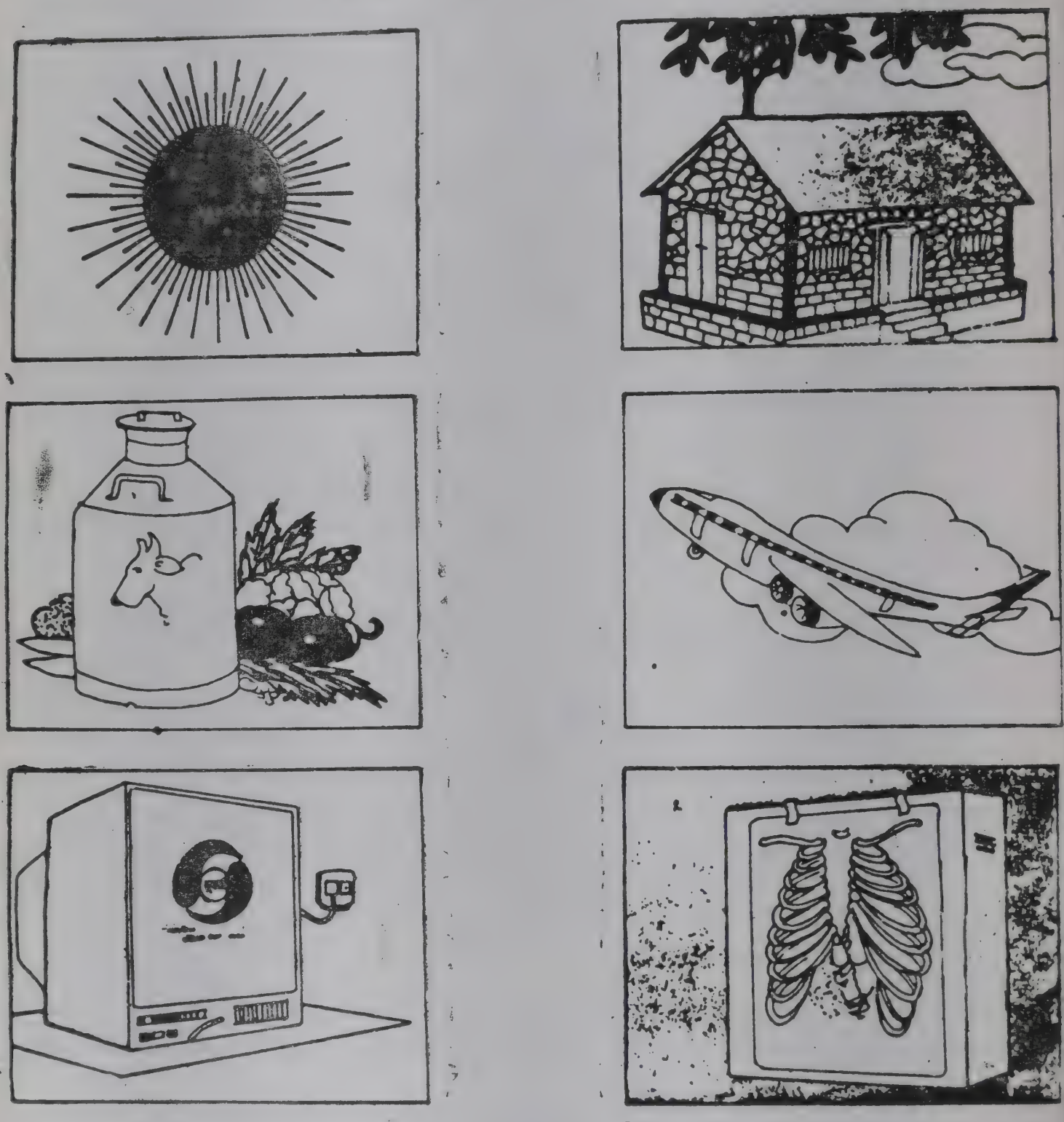
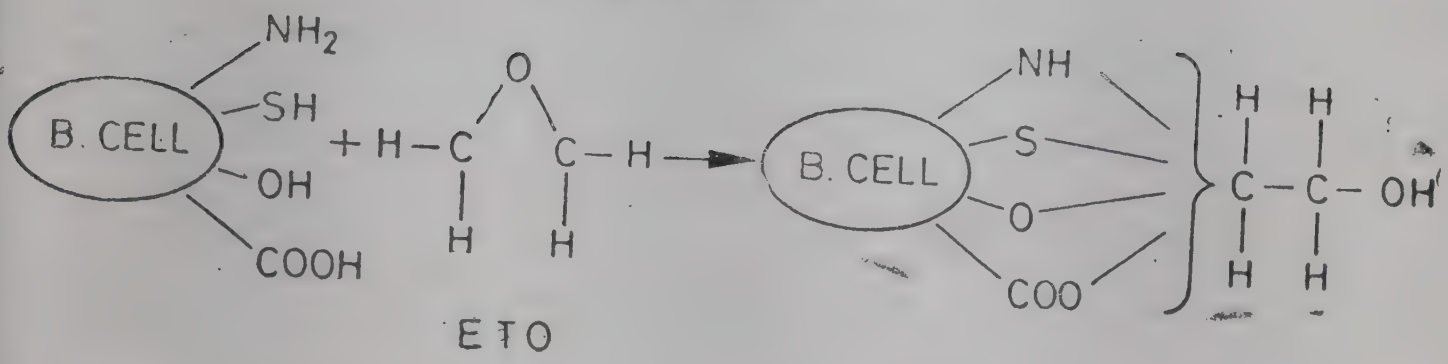


Figure 1

Figure 2

ALKYLATION



Reaction of E TO on Bacterial Cell by Alkylation

ANNEXURE—1

I. F. → Inactivation Factor

$$\text{I. F.} = \frac{\text{Pre-Sterilization Count}}{\text{Post-Sterilization Count}}$$

In case I.F. = 10^6

log (I.F.) = 6

$$\text{Safty Factor} = \frac{\text{Inactivation Factor}}{\text{Presterilization Count}}$$

ANNEXURE—2

Complete Destruction Below 10 Kilo Gray

A. Yeast and yeast like fungi
   - S. cerevisiae
   - C. albicans

B. Molds and molds like fungi
   - As. niger
   - As. fumigatus

TABLE 1

Factors Affecting the Sterilization Processes

Factors	Dry Heat	Moist Heat	Ethylene Oxide (Eto)	Formal-dehyde (HCHO)	Radiation
Temperature	X	X	X	X	/
Pressure	/	X	X	X	/
Vacuum	/	X	X	X	/
Humidity	/	NA	X	X	/
Post-sterilization drying/degasing	NA	X/ /	/ /X	/ /X	NA
Time	X	X	X	X	X

(X) : Affects the process; (/) : Does not affect the process;
(NA) : not applicable

TABLE 2

Factors Affecting the Sterilization Processes (Contd.)

Factors	Dry Heat	Moist Heat	Ethylene Oxide (EtO)	Formal-dehyde (HCHO)	Radiation
Product density	X	X	X	X	X
Choice of Packing	Narrow	Narro	Narrow	Narrow	Wide
Conditions	170-140°C	121° C	50° C	55—60° C	25 kGy
	1-3 hrs	15 min.	40/60%	80/90%	(2.5 Mega
		15 psi	RH 15 psi	RH	rads)
			6 hours		

(X) : Affects the process; RH : Relative humidity;
psi : Pounds per square inch; kGy : Kilo Gray

TABLE—3

Characteristic of Sterilization Processes

Factors	Dry Heat	Moist Heat	Ethylene Oxide (EtO)	Formal dehyde (HCHO)	Radiation
Type of process	Batch	Batch	Batch	Batch	Continuous
Mode of antibacterial action	Denatura-tion of protein	Coagula-tion of protein	Alkylation	—	Damages D.N.A.
Sterilization in the shipper pack	Not possible	Not possible	Not possible	Not possible	Possible

TABLE 4

Characteristics of the Sterilization Processes (Contd.)

Factors	Dry Heat	Moist Heat	Ethylene Oxide (EtO)	Formal-dehyde (HCHO)	Radiation
Log of inactivation factor	—	15—20	8—9	—	9—860
Residual toxicity	Nil	Nil	Yes, due to EtO, ETG & ETCH.	Yes, due to HCHO	Rare

ETG : Ethylene Glycol; ETCH : Ethylene Chlorohydrin

TABLE 5

Gram-positive Microorganism	Log (I.F.)
Staph. aureus	139
C. acnes	86
D. pneumoniae	88
S. lutea	28

TABLE 6

Gram-negative Microorganisms	Log (I.F.)
Ps. aeruginosa	860
E. coli	50-143
S. paratyphi B	130
K. pneumoniae	104
A. aerogenes	45

TABLE 7

Spore Forming Aerobes	Log (I.F.)
B. globigii	21
B. subtilis	10—15
B. stearothermophilus	12
B. pumilus	8—10

TABLE 8

Spore Forming	Log (I.F.)
Anaerobes	
Cl. sporogene	9—11
Cl. welchi	9
Cl. tetani	8—11
Cl. botulinum	8—11

TABLE 9

Biological Indicator Organism

Sterilization	Organism
Moist Heat	Bacillus stearothermophilus
Dry Heat	Bacillus subtilis var niger
Ethylene oxide	Bacillus subtilis var niger
Radiation treatement	Bacillus pumilus E 601

Patient Transport System in Urban Health Community [UHC] in Emergency

BY

PROF. N.P. SINGH

Injuries of various types-Road Accidents, Collapse due to heart attack, high blood pressure, and industrial accidents etc. are on the increase due to increased pace of life and industrialization of the society. Hence, with the increase in number of accidents, expeditious patient transport is vital.

The Chair Stretcher Trolley (manufacture by FERND WASHINGTON, USA) has been used in Suzuki Ambulance services in New Delhi and has been versatile from the view point of below mentioned features.

1. It has two levels of adjustment-one as the ground level at the height of 8 inches only thus permitting shifting of patient from ground level (road side) to the trolley and the second level is at the waist height (32 inches) which permits movement and shifting of the patient in the ambulance.

2. The upper part of the trolley permits positioning the patient at any level between 0°—90° with different inclined levels being possible. Thus permitting Oxygen Therapy in patients during transit.

3. The trolley is made of aluminium and this is monoeverable in a small area from 0—360° without any difficulty. The trolley weight is 21 kgs which would permit lifting the patient on the trolley even by two persons—one on the either side and movement of the patient on the stair case manually, in case elevaters are not available.

4. The patient can be wheeled inside the ambulance by a single rescuer/person/ helper by pushing the trolley inside the ambulance on a ramp which is at the trolley height and as soon as the ground wheels have gone in, the entire trolly collapses on the ground level (8 inches) by a latch pressure system, thus permitting patient transport by one person only.

5. Similarly, patient can be wheeled out of the ambulance from rear end by one person only as the trolley assumes waist height on being pulled up as the collapsed trolley comes on its own four wheels, thus permitting unloading of the victim by one person/ helper only.

6. The trolley can be convered in to a 'chair' position and can be easily wheeled out in an easy manner and can be easily accomodated in the lift for shifting the patient at different levels in a multistorey complex.

7. This system has been tried since January '86 in the Suzuki Ambulance service of Green cross society, India and is safe, efficient and dependable. It has also been fabricated by 505 Army Work Shop, Ministry of Defence, Govt. of India, who have been kind enough to help in this project.

DISCUSSION

The Chairman, Dr. Rikhy summarised all the four papers presented and opened the discussion by his comments that we all who are sitting in this hall are multi-purpose workers and in one sense that we had more than one work to perform. He mentioned that revolutionary changes are taking place in the hospitals inter alia PHC and health field. We hope this International Workshop will give a suitable Declaration which will bring the change towards better care for the community. The first paper for discussion was presentation made by Dr. Mrs. K. Kathpalia. Answering number of questions from Mr. Oomman Philip from Trivandrum, Dr. Gopal Krishna from Tamil Nadu and Dr. A.K. Godpayle from Dadar, Bombay, She informed that this study was undertaken on behalf of the W.H.O. and more details of the same can be had either from Dr. P.N. Ghei, Deputy Commissioner, Ministry of Health and FW of Delhi, or from Dr. Mrs. Tripta Bhasin, Asstt. Commissioner (RHS), Dte. General of Health Services, New Delhi. The dicussion was held on the training contents, orientation courses, training of trainers, safer camps etc. On the second paper of Dr. B.M. Sakharkar comment were made by Dr. Ramamoorthy, Dr. Datta and Dr. Rana from Shimla, The consensus arrived after discussion was that presentation made by Col. Sakharkar are useful for a small hospital as they have selected catchment area. Number of questions were raised on the paper presented by Mr. Sharma and he clarified many doubts. As far as costs of Gama Ray sterilisation are concerned, if the things are on rate contract, it becomes easier. Sterility with gamma rays is life long if the pockets are not damaged. Per contra shelf life for autoclave sterilised products is of week. Shelf life is confirmed on the pack and are correct if the pack remains intact. He also informed that second Gamma Ray plant is being set up in Bangalore in collaboration with Government of Karnataka and Kidwai Institute of Oncology and the Plant will be named "Rashmi" and dedicated to the nation in the near future. The importance of use of disposable one syringe one needle in rural areas for immunisation programme was stressed. Mrs. Karimunisa from Andhra Pradesh commented that the use of disposable material will reduce the work of nursing staff at the ward level.

The last discussion was on demonstration of a trolley for Patient Transport in urban health community developed by Prof. N.P. Singh, New Delhi. He informed that the trial is continuing, the repair cost is minimal and as a matter of fact, repair cost practically nil. It is made of material which is widely and readily available in India. This information was provided in answer to questions from Mrs. A.D. Malhotra and Dr. Shipra Banerjee. The Chairman thanked all Speakers and participants for high quality of presentation and discussion standards.

St. John's Medical College & Hospital

ADMISSION ANNOUNCEMENT

Eligibility : MBBS, B.Sc., Nursing, or B. Pharm with 12 years experience; B.A., B.Sc., B. Com., R.N.R.M., or equivalent with 5 years experience. Organizational sponsorship essential

Selection : Screening through written examination and personal interview at Bangalore.

Application : A crossed Bank Demand Draft for Rs. 50/- drawn in favour of 'CBCI SOCIETY FOR MEDICAL EDUCATION', payable in Bangalore, should be sent along with request for application to the Admissions Officer, St. John's Medical College & Hospital, Bangalore : 560 034.

Last date for receipt of request for application form and course details :
JUNE 15, 1989

Last date for receipt of completed application form :
JULY 15, 1989

SHORT COURSES/SEMINARS

Human Resources Development : DURATION—
Two Weeks—August 14—26, 1989.

Advanced Accounting in Health Care : DURATION—
Two Weeks—November 13-25, 1989

For Application write to : The Coordinator, Health Care Administration,
St. John's Medical College & Hospital,
Bangalore : 560 034

Release of Journal of 'Hospital Administration' Silver Jubilee Issue,

By

Dr. Herbert L. Whittier*

Before the post lunch Scientific Session V was started the important event of the lay was the release of Journal 'Hospital Administration' Silver Jubilee Issue, June-1988 y Dr. Herbert L. Whittier, Associate Director, KIFPH, MSU, USA. Dr. P.N. Ghei, ecretary General, IHA. New Delhi (India) informed that we have taken this opportunity o have Silver Jubilee Publication of Journal 'Hospital Administration' to be released by r. Whittier. An important feature of this Journal is that Mrs. Pramila Ghei, Secretary nd KIFPH Fellow has taken over as Business Editor of the Journal. Dr Ghei thanked e new Business Editor and the Editor Dr. A.K. Khokhar for an excellent get up of the ournal and publishing it on time.

Dr. Whittier released the Journal and made the following statement :

"Let me express my appreciation for the invitation to join you and Indian Hospital ssociation on the occasion of the Association's Journal Hospital Administration twenty h anniversary. I appreciate the honour of being selected to present and dedicate e special anniversary issue of the Indian Hospital Association's Silver Jubilee Volume the Journal 'Hospital Administration' June. 1988 to the assembled distinguished group members of the Association and the Kellogg International Fellowship Programme llows.

The Journal provides an excellent chronicle of the efforts of the Indian Hospital ociation to continually further the excellent service of health care and Silver Jubilee ue is a good example of the progress that has been made. It also shows the promise the dedicated members of the Association will continue in their efforts to achieve the for health care in India."

**Associate Director, KIFPH, MSU (USA)*

23-4-88

Scientific Session—V

Chairperson — Dr. Don Detmer,
Vice-President for Health,
University of Virginia,
Charlottevile-Virginia, U.S.A.

Speaker — **PHC in England**
Mrs. L. Julia Cumberlege,
Chairman, Brighton Health Authority,
England

Developing Primary Health Care

BY

*MR. BRIAN JARMAN, **MRS. JULIA CUMBERLEGE

ABSTRACT

Primary health care is best provided by a primary health care team of general practitioners, community nurses, and other staff working together from good premises and looking after the population registered with the practice. It encourages personal and continuing care of patients and good communication among the members of the team. Efforts should be made to foster this model of primary care where possible and also to evaluate its effectiveness. Community services that are not provided by primary care teams should be organised on a defined geographical basis, and the boundaries of these services should coincide as much as possible. Such arrangements would facilitate effective community care and health promotion and can be organised to work well with primary care teams.

The patient's right to freedom of choice of a doctor, however, should be retained, as it adds flexibility to the rigidity of fixed geographically based services.

INTRODUCTION

Many agencies provide health care and social services in the community, often overlapping considerably.[1] This can cause confusion and wastage of resources. Several of these services are provided to a geographically defined population, but the boundaries of the service provision by the different agencies do not always coincide. There would be considerable benefit in defining common boundaries for these areas now, while some are still in the early stages of development. This would enable information about the needs of the population, based on census and other data, to be shared. It would also avoid the unnecessary duplication of services, allowing decisions to be made about the most effective and efficient use of resources, and would allow the population of an area to have a say in the decisions that are made about the services provided for them.

The underlying theme of the two government reports on primary health care published last April[2 3] was the importance of the primary health care team. This was also the case with the two reports on the same subject that preceded them by five years[4 5] and

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**Chairman, Brighton Health Authority.

the recently published report from the social services committee of the House of Commons.[6]

This paper is not concerned with those recommendations of the community nursing review which the government has decided not to implement.[3 6] We believe that primary care is best organised by a well functioning primary care team, with patients being registered, often for many years, with one general practitioner whom they choose and having access to the coordinated services of other members of the team. Though we believe that this model should be encouraged whenever possible, it should be borne in mind that, despite the agreement of all the reports mentioned above, this is to a certain extent an article of faith that should if possible be tested using as criteria satisfaction of the patients with the services provided and satisfaction of the health workers with their jobs, together with measures of outcome in terms of improved quality of care for patients. This applies equally to geographically organised community care, and we support attempts to evaluate different models of care.

The Present Position

The agencies providing community services are mostly under the control of the Department of Health and Social Security or the Department of the Environment. They include the following, which are provided almost entirely on a fixed geographical basis :

The National Health Service provides hospital priority care services for mental illness, mental handicap, physical handicap, and the elderly; and day hospitals and day care. It also covers community medicine, health education, health visitors and district nurses (when working geographically), speech therapists, occupational therapists, domiciliary physiotherapists, chiropodists, and dentists; community diabetic nurses, midwives, and psychiatric nurses; outreach services for terminal care and incontinence, stoma nurses, special drug and alcohol services, and so on.

Local authorities provide home helps, meals, day centres, residential homes, social workers, occupational therapists and home aids and adaptations, housing, education, and other services. They deal particularly with children, the elderly, the mentally and physically handicapped, and the mentally ill.

Social security services pay attendance allowance, mobility allowance, invalid care allowance, disability benefits, sickness and invalidity benefits, retirement pension, unemployment benefit, child benefit, and income maintenance—that is, supplementary benefit (including board and lodging payments for people in hostels and residential and nursing homes), housing benefit, and family income supplement.

Voluntary and Private Organisations provide a very wide range of services.

The only services that are not geographically based are the NHS family practitioner

services (general practitioners and attached health visitors district nurses, and so on and ancillary staff, pharmacists, dentists, and opticians), the acute hospital services (because general practitioners are free to make referrals to any hospital in the country), and some of the voluntary and private services

These different agencies provide interrelated services to groups of people living in the community, but the different structures within which the services are provided make it difficult for the providers to communicate with each other. The workers responsible have different training, different attitudes, different methods of employment, different management arrangements and accountability, and different geographical boundaries for their work.

Various agencies are currently developing new policies for community care because of factors such as the health service policy of transferring care to the community, the closure of large mental hospitals, the increasing numbers of elderly in the population needing care at home, and so on. Community psychiatric nurses, health visitors and district nurses, social workers, and some general practitioners have developed or are developing their own defined geographical areas that do not necessarily have the same boundaries. Local authority housing departments, hospital geriatric and psychiatric units, and social security offices have larger defined catchment areas that they cover, which also often do not coincide.

The cost of providing a service by one combination of agencies may be greater than the cost of another combination.[1] For instance, caring for ill elderly people by admitting them to a hospital or nursing home can be much more expensive than keeping them at home with the support of an attendance allowance (and possibly an invalid care allowance for the person in attendance) and home helps and district nurses and general practitioners from a primary care team visiting regularly. Usually patients want to stay in their own homes for as long as they can, and a move to a nursing home or hospital can be very unsettling for an elderly person, heightening confusion and accelerating physical deterioration. Coordinating these services and deciding on the most effective and efficient method of provision is difficult because of the complexity of community services and the fact that payments are made from different parts of the DHSS and other budgets. This leads to confusion—for patients and workers—and wastage. The increased mobility of people and the lack of common boundaries of health authority areas with local authority and family practitioner committee areas since the 1982 NHS restructuring of district health authorities and their boundaries have made things more difficult.

Positive Features and New Developments

The present system and recent developments in community care have some positive features that could be developed.

Firstly, many primary care teams offer a range of services under one roof. For instance, in the health centre in which one of us works there are general practitioners and their employed ancillary staff (general medical services); dentists, health visitors, and district nurses (some in the treatment room and others visiting in the district, mostly attached to practices), community psychiatric nurses, school nurses, a speech therapist, a midwife, a sex therapist, a dietitian, a health worker who speaks Bengali, and a community physiotherapist (district health authority); a full time social worker (local authority); counsellors provided by the Marriage Guidance Council (voluntary body); and someone giving advice about DHSS social security benefits.

At the centre staff from different disciplines meet regularly, both casually and at weekly practice meetings, at which there is no difficulty in deciding which group of workers is the most appropriate to deal with a particular problem. Usually there are common goals, and there is always a form of continuing mutual education when discussing the attitudes of different workers. There is no question of one person being in charge or of sectional interests in competing for patients, as can occur if the services work independently with poor communication. Each section does its own job as best it can and is glad of any help that can be provided by another member of the team. If a new social worker, nurse, or doctor is appointed several members of the team have a say in the choice. For people coming with a problem to the health centre it makes little difference how the services represented there are structured—they just pass easily from one to the other, as they are under the same roof. It is a system that works, and this has much to do with the services being in the same building and the staff meeting regularly.

Most general practitioners now work in group practices, and many have varians of this arrangement. The premises of the practice vary in standards—only one quarter of general practitioners work in health centres – and people have a continuing relationship with the doctors in the practice, whom they see three or four times a year. A lack of continuity of care is more a matter of the arrangements in the practice and the number of doctors in the group rather than whether the practice is located in a health centre or not.

Secondly, general practice in this country has evolved so that 94% of all doctor contacts in the community (NHS or private) are with NHS general practitioners.[7] The general household survey of 1982[7] showed the following breakdown of contacts made by 4079 elderly people in the month before the interview : doctor in surgery 938 people (23%), doctor at home 41 (10%), doctor at surgery and home 1264 (31%), district nurse or health visitor 245 (6%), chiropodist 326 (8%), home help 326 (8%), meals on wheels 82 (2%), lunch club or day centre 122 (3%), and a visit to a day centre 163 (4%), General

medical services account for 7% of the cost of the NHS,[8] not including the cost of the drugs prescribed by general practitioners, which is determined largely by agreements between the government and the pharmaceutical industry. Treatment in hospital normally results from referral by a general practitioner, and, in comparison with other developed countries, we have relatively low rates of admission to hospital and spend a low proportion of our gross national product on health services.

The system provides long term continuity of care and also a mechanism for transferring patients' medical notes when they move house. Throughout a patient's lifetime notes made by the general practitioner and letters between the practice and hospitals regarding referrals and admissions and so on move with the patient. As hospitals do not generally transfer patients' notes when they attend another hospital this is a valuable aspect of general practice in this country and enables a general practitioner, when referring a patient to a nurse or hospital, to give a summary of the relevant history.

Thirdly, in some areas different agencies have cooperated to define common boundaries and have set up local multidisciplinary teams to ensure coordinated services.

Finally, information technology can now help to give details of social conditions (and hence indicate the likely needs of the population) down to small areas such as post-code sectors, enumeration districts, electoral wards, or any combination of these. The location of different services and the boundaries of their normal working areas can also be charted and overlaid on maps of demographic and social factors to show the correspondence between services and local needs. Family practitioner committees are computerising all their records—which cover 97% of the population[3]—with one common, integrated system of software throughout the country. With postcoded addresses the distribution of general practitioners' practice populations can be mapped and the overlap with other services shown This system could be linked with community child health systems and eventually with hospitals. Standardised mortality ratios, infant and perinatal mortality rates, and measures of morbidity such as self reported sickness or disability and the proportion of low birthweight babies can also be linked with the social and service data for small areas, enabling the relation among health indices, social factors, and services provided to be monitored.

It would be relatively straightforward to produce data and maps by computers and give the information to local workers.[9] This would allow local data to be compared with those of larger areas or national data. Services, particularly preventive services, could be targeted at social groups with the greatest need, with the aim of reducing morbidity and mortality.

Community Care Areas

The community nursing review pointed out the potential advantage to the community

nursing services if they were managed on a neighbourhood basis.[2] As an extension of this principle local community care areas with the same boundaries for community nurses, social workers, and others working geographically could be drawn up by the local authority and health authority acting together with local residents. Each area would cover 10000-25000 people, preferably comprising groups of electoral wards. Statistics about the social conditions of the population of each area (numbers of elderly people, homeless families, and so on) could be used to work out the levels of service needed. Each authority could set a local budget for the services it provided in the area and plan with the local residents how these resources should be deployed most effectively. Staff would have to be trained to adapt to this approach. Eventually it would be possible to integrate data about housing, social security payments, hospital usage, and so on even for small areas and so produce the information necessary for planning the most advantageous mix of services.

This raises the whole question of virement—transferring money from one budget to another. Theoretically this is possible at the moment through the machinery of the existing joint consultative committee at the health authority and local authority level, but there are several difficulties with this mechanism, and the money in question constitutes less than 1% of the NHS budget.[1] If there is a change in the balance between different community services the relevant financial resources need to be transferred. Eventually the switch of resources between social security, local authority, and health budgets in a budget of a common community care area could be envisaged, with the aim of providing better and cheaper services. Before this is possible, however, the data needed to make the budgeting decisions have to be gathered for each small area. Such data could also give information about the variation in the existing provision of resources among different community care areas in relation to their key social and demographic characteristics.

The efficiency of different services in an area could also be studied. A district nurse may have a total of 1500 visits to patients a year,[2] mostly in the home, whereas a general practitioner will have, on average, over 7000 consultations a year, of which about 900 will be in patients' homes.[10] General practitioners are usually requested to visit a patient at home, or they make an appointment to do so for a routine visit for a chronic condition. Health visitors and district nurses spend 16% and 24% of their time, respectively, travelling'[2] and often find that patients are not at home when they arrive, a wasteful practice that rarely happens with general practitioners. General practitioners hold about 88% of their consultations in their surgeries,[10] and community nurses might also be able to do this if they had a base in which to do so—for example, in a health centre. This would enable them to make the maximum use of their skills and to develop the extended role of the nurse.

The community nursing review suggested that health care associations should be formed. Their structure could vary infinitely, from an antenatal group that can see a

potential for improving their services or an ethnic minority who do not know how to use the services, to a more substantial group, under the auspices of the community health council, that covers more than one neighbourhood and will help to monitor and plan services with a view to maximising their effectiveness. Local residents would have some say in decisions about planning, allocating resources, and quality control of services that they receive and ultimately pay for. Voluntary workers could help the professionals—for instance, with prevention campaigns and caring for the elderly. There could be close collaboration between people in the community and staff of the health and social services, allowing collective responsibility and collaboration at a local level, perhaps covering only a few thousand people. It is, however, important to ensure that the views put forward are representative of the local popu ation and those directly using a particular service, not only those of a particular service, not only those of a particular pr ssure group.

General practitioners working in primary care teams normally discuss with other members of the team in a confidential way the aspects of a patient's medical history that are relevant to the management of the patient by the team. Social workers' records, however, are held separately from the notes of the general practitioner and community nurse (and this will continue for legal and confidentiality results). But the possibility of these professionals working more closely together would allow relevant information held in different sets of records to be exchanged more easily when appropriate, such as in cases of suspected child abuse.

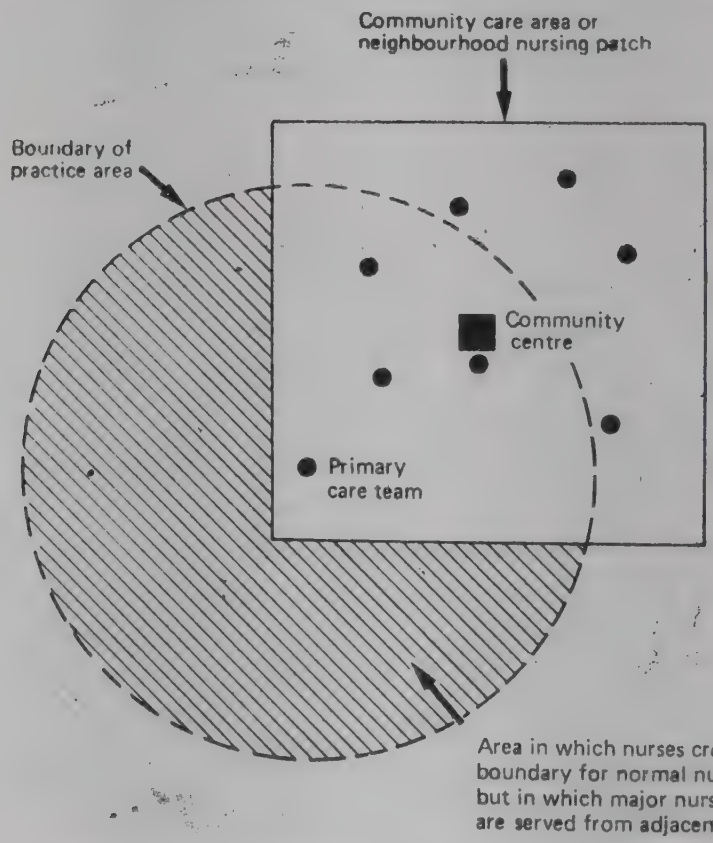
Primary Care Teams and Community Care Areas

General practitioners' lists of patients are traditionally not based on a defined geographical zone other than the loose arrangement implied by the contract between the general practitioner and the family practitioner committee, in which the general practitioner agrees to visit patients at home if necessary and therefore can accept only patients living within visiting distance of the surgery. Fears have been expressed about how general practitioners' practice areas can be made to overlap with community care areas as described above and still retain the freedom of patients to choose which general practitioner they register with. The benefits of this freedom and the continuing doctor-patient relationship, which is a cornerstone of our general practice system, are very great.[2-6] So, also, in a geographical zoning system, are the benefits of knowing the exact areas for which a service is responsible if the service does not have the advantage of a registered list of clients (as a general practice has). There would, however, be an advantage in general practitioners continuing to be able to take patients from over the boundaries of a community care area, as this would leave an element of consumer choice in what otherwise would be too inflexible a system.

It is obviously best for the community nurses working in a primary care team with

general practitioners to remain with that team, but they could be responsible to the neighbourhood nurse manager for their training, sickness cover, weekened rota, and so on. The general practitioners and nurse manager would have to decide how best to cover registered patients who live in another area. Patients with few nursing needs should be covered by allowing flexibility in the system so that a nurse can cross the boundary. It would be only the very few patients who are highly dependent on nursing care (or living a long way away) who would be best covered by an arrangement in which the nurse manager contacts her neighbouring colleague to arrange for the patients' nursing needs to be dealt with by the neighbouring patch (figure). This arrangement must be clearly understood by all concerned so that nurses know that they are working with patients who are registered with the practice (though they could still decide among themselves to divide the practice population geographically if they wished).

General practitioners might slowly decide to divide their patients geographically more in future if they see advantages in working with one group of workers, preferably based in the same building and covering a wide range of social and health services for their area. If the areas covered 10,000-25,000 people (two to five electoral wards, which are roughly the size of the area covered by a medical practices committee) and most general practi-


Community care area or neighbourhood nursing patch
Boundary of practice area
Community centre
Primary care team
Area in which nurses cross patch boundary for normal nursing needs but in which major nursing needs are served from adjacent patch

Relation between neighbourhood nursing practices (community care areas) and primary care teams

tioners were limiting their lists to the community care area patients would still have a choice of between five and 12 general practitioners and could even go over the boundary to another general practitioner who was still taking patients from further a field if they preferred the services of that primary care team.

We thank Brian Abel-Smith, John Chisholm, John Hasler, Howard Hiatt, John Horder, Geoffrey Rivett, Colin Waine, and Michael Wilson for their comments on an earlier draft of this paper and others working in primary care with whom we discussed the contents. The opinions expressed in this paper are of course our own.

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DISCUSSION

This Session was chaired by Dr. Don Detmer and on the paper presented by Mrs. J. Cumberlege, Chairman commented on the enthusiasm she has shown in conducting the survey and its relevance for all of us. He remarked that there is a need to bring about change and decentralisation.

Mrs Cumberlege answering to questions from Dr. (Mrs.) Gloria Smith from USA and others informed that the report is produced by Her Majesty Stationery Office and the methodology was simple based on public opinion. She remarked that there is an international shortage of nursing personnel and attributed this to low pay and low status. In the discussion followed Dr. (Mrs.) Afaf Meleis-USA commented that the survey was arranged through a firm of Government and it costed two thousand sterling. In answer to another question, she informed that there is a monopolistic situation in National Health Services where ninety eight percent of people are covered. She informed that in England people from all walks of life take active interest and, therefore, group has not become rigid and bureaucratic in its approach. There is considerable inter action between Nurses and community health workers leading to areas of overlaps and gaps. Mr. Hardie commented on the implications of remarks that it gives an impression that Community Health Workers are doing the nurses work and vice versa. He said the situation on ground is not so and proper people at proper level are essential. Community Health Workers are impor ant people in the community while the Nurse by and large work in an institutional hospital base though they are taking lot of interest of late in community programme. Dr. Detmer summarised and closed the discussion with the remarks that the nurses have definite reputation and place in society and their work cannot be equated with community health workers. He congratulated the speakers for an excellent presentation.

23-8-88

Wrap Up Session

The Wrap Up Session was chaired by Dr. S.D. Vohra, Chairman, Scientific Committee of I.H.A. and he read out 1985 New Delhi Declaration on Hospital and Primary Health Care which was adopted at the International Conference on Hospital and Primary Health Care held in New Delhi in 1985. He hoped that the Declaration has been studied by all participants as the same was distributed as part of the background document at the time of registration. He also read out the draft Declaration which has been worked out by the Scientific Committee of IHA based on trend of discussions both formal and informal and also interaction of members of the Scientific Committee with delegates from abroad and India and KIFPH Fellows in the last 3 days. He invited comments on the draft Declaration and opened the Declaration for discussion and formal adoption. In the discussion, Mr. Robert De Vries, Dr. Roy J. Gerard, Mr. Miles C. Hardie, Mrs. Pramila Ghei, Dr. Don Detmer, Dr. Don White, Dr. P.N. Ghei, Dr. S.S. Rikhy and many others took part. The modified Declaration was finally adopted and read out by Dr. P.N. Ghei, Secretary General, IHA, New Delhi which will be called 'New Delhi Declaration' on Urban Health Care (UHC), 1988. This Declaration on Urban Health Care was finally adopted. The text of the 1985 and 1988 New Delhi Declaration on Hospital and PHC and New Delhi Declaration on UHC follows.

New Delhi Declaration on Hospital & Primary Health Care 1985

New Delhi Declaration on Hospital and Primary Health Care was adopted at the International Conference on Hospital and Primary Health Care held in January, 1985.

The Declaration reads as under :

1. Emphasis has not to be on whether hospital have a role in Primary Health Care but on how hospitals can become fully involved in the practice of Primary Health Care.

2. In order to promote Primary Health Care, ten priorities emerged :

   2.1 The formulation of a health policy centered on Primary Health Care.

   2.2 The development of the health infrastructure with special reference to referrals.

   2.3 The development of sensitive indicators.

   2.4 The identification of appropriate technology.

   2.5 The development of health manpower.

   2.6 The education and training of all categories of staff.

   2.7 Community involvement

   2.8 The development of a suitable health information system.

   2.9 The optimisation of financial support and the maximisation of scarce resources.

   2.10 The monitoring and periodic evaluation of outputs and programmes to effect corrective steps.

3. All agencies—governmental, corporate, voluntary and private must work together towards the achievement of pre-set goals and targets with clear dates.

4. Progress in the implementation of Primary Health Care should be reviewed by a suitable forum at specified intervals.

New Delhi Declaration on Urban Health Care 1988

1. Each country must have a National Health Policy.
2. Urban Health Care (UHC) needs to be restructured on the concept of Primary Health Care and neighbourhood or patch work approach based on the need of the people.
3. Community in slums, shanty areas, jhuggis must be given top priority.
4. Precedence must be given in target communities to women, children and the elderly in view of limited resources.
5. Sensitive indicators like Infant Mortality Rate and Maternal Mortality Rate need be closely monitored.
6. There should be no effort on social engineering of urban community but they may be provided safe potable water, facilities of sewage disposal and garbage removal on priority basis.
7. The approach in UHC should aim at ensuring intrasectoral dialogue, intersectoral coordination and even a trans-sectoral approach. Both vertical and horizontal integration of health providers is needed.
8. The community hospital in urban area has a pivotal role in providing and supporting UHC.
9. In order to ensure acceptance of Family Welfare Programme, it is imperative to apply interventions like Growth Monitoring, Oral re-hyderation, Breast Feeding. Child Spacing, Immunisation, applied nutrition and Health Education coupled with female education, raising age of marriage and social development.
10. There should be a system to ensure periodic evaluation so that quality services are provided to the community with subsequent reallocation based upon the findings. Respective Governments should allocate more resources.
11. U.H.C. is best provided through efforts of multidisciplinary team.
12 Professionalisation in Management and an inbuilt system of Health Professionals education at all levels to optimise existing resources.

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ESSAY COMPETITION, 1989

The guidelines for the Essay competition for 1989 are as under :—

1. The Essay Competition is open to all health personnel engaged in hospital and health administration in India and having a degree of diploma in health or hospital administration.
2. The topic for Essay for 1989 is **'Quality Assurance Programme'**.
3. The Essay submitted by the candidates will be adjudged by a Committee constituted for this purpose by the Indian Hospital Association, Executive Committee.
4. The author of the Essay best adjudged will be requested to present the same, in person, during National Hospital Convention to be held in November, 1989. Indian Hospital Association will pay travel expense first class both ways for this purpose.
5. Six copies of the Essay will be submitted by the candidate and the maximum length of the Essay may be 6 double space typed pages.
6. The Essay will be the property of the Indian Hospital Association and the same may be published in Journal 'Hospital Administration'.
7. The envelope containing Essay may be sent by name to 'The Secretary, Indian Hospital Association' at the above address under 'Registered Cover'.
8. The last date for the receipt of Essary is 30-9-89 and no Essay after that date will be accepted.
9. The Members of the Executive Committee and Editorial Board for the year 1989 will not be eligible to participate in the Essay Competition of 1989.

(Mrs. P. Ghei)
Secretary

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IMPORTANT ACTIVITIES

Second Semester 1989

1. **Management Seminar for Medical Record Sciences**
   September 7—9, 1989, New Delhi

2. **Dr. James S. Tong Memorial Lecture**
   9 September 1989, New Delhi
   By Dr. U. Ko Ko, Regional Director, SEARO, WHO, New Delhi

3. **18th Hospital Management Seminar**
   6th November—12th November 1989, New Delhi

4. **National Hospital Convention & Annual Convention**
   on 11th & 12th November 1989
   Scientific Theme : Hospital & Drug.

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